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(54) **METHODS, INSTRUMENTS AND DEVICES FOR EXTRAGASTRIC REDUCTION OF STOMACH VOLUME**

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(56) **References Cited**

U.S. PATENT DOCUMENTS

233,475 A 10/1880 Cook et al.
659,422 A 10/1900 Shidler
(Continued)

FOREIGN PATENT DOCUMENTS

EP 0 938 871 9/1999
EP 1 016 377 7/2000
(Continued)

OTHER PUBLICATIONS

About the Vertical Sleeve Gastrectomy. Mar. 24, 2006, pp. 1-1. http://obesityhelp.com/forums/VSG/about.html.
(Continued)

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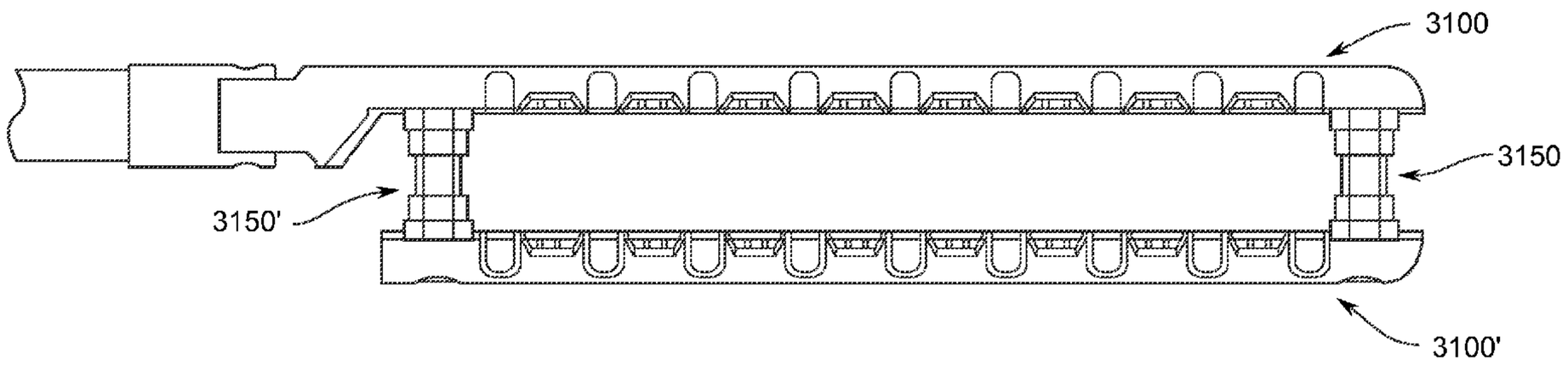
(57) **ABSTRACT**

Methods, instruments and systems are provided for separating opposite walls of the stomach by extragastric application of suction. Plication of the stomach can be performed between the separated walls after which the separate walls are brought back toward one another. In another aspect, methods, instruments, devices and systems are provided for reducing the effective volume of a stomach by performing one or more extragastric plications of the stomach.

21 Claims, 84 Drawing Sheets



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(56) **References Cited**

U.S. PATENT DOCUMENTS

780,392	A		1/1905	Wanamaker et al.
789,467	A		5/1905	West
1,461,524	A		7/1923	Goddard
2,579,192	A		12/1951	Kohl et al.
2,646,298	A		7/1953	Leary
2,697,624	A		12/1954	Thomas et al.
2,734,299	A		2/1956	Masson
2,825,592	A		3/1958	Semple
3,326,586	A		6/1967	Frost et al.
3,470,834	A		10/1969	Bone
3,521,918	A		7/1970	Hammond
3,571,864	A		3/1971	Oger
3,664,435	A		5/1972	Klessig
3,675,639	A		7/1972	Cimber
3,713,680	A		1/1973	Pagano
3,756,638	A		9/1973	Stockberger
3,873,140	A		3/1975	Bloch
3,931,667	A		1/1976	Merser et al.
3,976,079	A		8/1976	Samuels et al.
4,006,747	A		2/1977	Kronenthal et al.
4,052,989	A		10/1977	Kline
4,060,089	A		11/1977	Noiles
4,133,315	A		1/1979	Berman et al.
4,210,148	A		7/1980	Stivala
4,246,893	A		1/1981	Berson
4,291,698	A		9/1981	Fuchs et al.
4,328,805	A		5/1982	Akopov et al.
4,416,267	A		11/1983	Garren et al.
4,458,681	A		7/1984	Hopkins
4,472,226	A		9/1984	Redinger et al.
4,485,805	A		12/1984	Foster, Jr.
4,493,323	A		1/1985	Albright et al.
4,558,699	A		12/1985	Bashour
4,592,339	A		6/1986	Kuzmak et al.
4,592,342	A		6/1986	Salmasian
4,621,640	A		11/1986	Mulhollan et al.
4,669,473	A		6/1987	Richards et al.
4,694,827	A		9/1987	Weiner et al.
4,696,288	A		9/1987	Kuzmak et al.
4,705,040	A		11/1987	Mueller et al.
4,714,281	A		12/1987	Peck
4,723,547	A		2/1988	Kullas et al.
4,738,255	A		4/1988	Goble et al.
4,739,758	A		4/1988	Lai et al.
4,744,364	A		5/1988	Kensey
4,750,492	A		6/1988	Jacobs
4,803,985	A		2/1989	Hill
4,823,794	A		4/1989	Pierce
4,899,747	A		2/1990	Garren et al.
4,955,913	A		9/1990	Robinson
5,002,550	A		3/1991	Li
5,033,481	A		7/1991	Heyler, III
5,041,129	A		8/1991	Hayhurst et al.
5,084,061	A		1/1992	Gau et al.
5,100,421	A		3/1992	Christoudias
5,112,310	A		5/1992	Grobe
5,123,914	A		6/1992	Cope
5,129,912	A		7/1992	Noda et al.
RE34,021	E		8/1992	Mueller et al.
5,151,086	A		9/1992	Duh et al.
5,188,104	A		2/1993	Wernicke et al.
5,192,070	A	*	3/1993	Nagai et al. 271/90
5,217,470	A		6/1993	Weston
5,220,928	A		6/1993	Oddsen et al.
5,234,454	A		8/1993	Bangs
5,246,456	A		9/1993	Wilkinson
5,257,713	A		11/1993	Green et al.
5,258,000	A		11/1993	Gianturco et al.
5,258,015	A		11/1993	Li et al.
5,259,399	A		11/1993	Brown
5,269,809	A		12/1993	Hayhurst et al.
5,279,551	A		1/1994	James
5,282,832	A		2/1994	Toso et al.
5,290,217	A		3/1994	Campos
5,292,344	A		3/1994	Douglas
5,334,200	A		8/1994	Johnson
5,345,949	A		9/1994	Shlain
5,354,271	A		10/1994	Voda
5,364,408	A		11/1994	Gordon
5,382,238	A		1/1995	Abrahamson et al.
5,391,182	A		2/1995	Chin
5,403,326	A		4/1995	Harrison et al.
5,405,352	A		4/1995	Weston
5,423,872	A		6/1995	Cigaina
5,428,123	A		6/1995	Ward et al.
5,433,723	A		7/1995	Lindenberg et al.
5,445,608	A		8/1995	Chen et al.
5,470,337	A		11/1995	Moss
5,472,446	A		12/1995	de la Torre
5,480,406	A		1/1996	Nolan et al.
5,496,311	A		3/1996	Abele et al.
5,507,754	A		4/1996	Green et al.
5,545,171	A		8/1996	Sharkey et al.
5,545,178	A		8/1996	Kensey et al.
5,549,621	A		8/1996	Bessler et al.
5,554,162	A		9/1996	DeLange
5,571,116	A		11/1996	Bolanos et al.
5,573,540	A		11/1996	Yoon
5,591,177	A		1/1997	Lehrer
5,601,604	A		2/1997	Vincent
5,626,614	A		5/1997	Hart
5,634,936	A		6/1997	Linden et al.
5,647,836	A		7/1997	Blake, III et al.
5,669,935	A		9/1997	Rosenman et al.
5,676,674	A		10/1997	Bolanos et al.
5,690,691	A		11/1997	Chen et al.
5,716,368	A		2/1998	de la Torre et al.
5,725,557	A		3/1998	Gatturna et al.
5,788,715	A		8/1998	Watson, Jr. et al.
5,792,153	A		8/1998	Swain et al.
5,846,254	A		12/1998	Schulze et al.
5,865,730	A	*	2/1999	Fox et al. 600/201
5,888,196	A		3/1999	Bonutti
5,897,562	A		4/1999	Bolanos et al.
5,921,978	A		7/1999	Thompson et al.
5,931,788	A		8/1999	Keen et al.
5,938,669	A		8/1999	Klaiber et al.
5,947,983	A		9/1999	Solar et al.
5,951,590	A		9/1999	Goldfarb
5,957,939	A		9/1999	Heaven et al.
5,961,440	A		10/1999	Schweich, Jr. et al.
5,971,447	A		10/1999	Steck, III
5,993,473	A		11/1999	Chan et al.
6,006,002	A		12/1999	Motoki et al.
6,013,053	A		1/2000	Bower et al.
6,067,991	A		5/2000	Forsell
6,080,160	A		6/2000	Chen et al.
6,097,984	A		8/2000	Douglas

(56) **References Cited**

U.S. PATENT DOCUMENTS

6,102,922	A	8/2000	Jakobsson et al.	
6,113,609	A	9/2000	Adams	
6,143,006	A	11/2000	Chan	
6,162,234	A	12/2000	Freedland et al.	
6,174,280	B1	1/2001	Oneda et al.	
6,186,149	B1	2/2001	Pacella et al.	
6,270,530	B1	8/2001	Eldridge et al.	
6,420,452	B1	7/2002	Gunatillake et al.	
6,425,900	B1	7/2002	Knodel et al.	
6,437,073	B1	8/2002	Gunatillake et al.	
6,447,533	B1	9/2002	Adams	
6,454,785	B2	9/2002	De Hoyos Garza	
6,475,136	B1	11/2002	Forsell	
6,488,691	B1	12/2002	Carroll et al.	
6,491,707	B2	12/2002	Makower et al.	
6,494,888	B1	12/2002	Laufer et al.	
6,500,148	B1	12/2002	Pinchuk et al.	
6,506,196	B1	1/2003	Laufer	
6,511,490	B2	1/2003	Robert	
6,535,764	B2	3/2003	Imran et al.	
6,551,241	B1	4/2003	Schultz	
6,558,400	B2	5/2003	Deem et al.	
6,572,627	B2	6/2003	Gabbay	
6,656,182	B1	12/2003	Hayhurst	
6,663,639	B1	12/2003	Laufer et al.	
6,669,713	B2	12/2003	Adams	
6,675,809	B2	1/2004	Stack et al.	
6,726,622	B2	4/2004	Spence et al.	
6,736,793	B2	5/2004	Meyer et al.	
6,746,458	B1	6/2004	Cloud	
6,746,460	B2	6/2004	Gannoe et al.	
6,755,869	B2	6/2004	Geitz	
6,773,441	B1	8/2004	Laufer et al.	
6,790,213	B2	9/2004	Cherok et al.	
6,821,285	B2	11/2004	Laufer et al.	
6,835,200	B2	12/2004	Laufer et al.	
6,869,395	B2	3/2005	Page et al.	
6,900,055	B1	5/2005	Fuller et al.	
6,908,487	B2	6/2005	Cigaina	
6,981,978	B2	1/2006	Gannoe	
6,994,715	B2	2/2006	Gannoe et al.	
7,033,373	B2	4/2006	de la Torre et al.	
7,037,315	B2	5/2006	Sancoff et al.	
7,037,344	B2	5/2006	Kagan et al.	
7,131,980	B1	11/2006	Field et al.	
7,153,314	B2	12/2006	Laufer et al.	
7,160,312	B2	1/2007	Saadat	
7,167,750	B2	1/2007	Knudson et al.	
7,214,233	B2	5/2007	Gannoe et al.	
7,223,277	B2	5/2007	DeLegge	
7,255,675	B2	8/2007	Gertner et al.	
7,310,557	B2	12/2007	Maschino et al.	
7,334,822	B1	2/2008	Hines, Jr.	
7,338,433	B2	3/2008	Coe	
7,354,454	B2	4/2008	Stack et al.	
7,374,565	B2	5/2008	Hassler et al.	
7,399,304	B2	7/2008	Gambale et al.	
7,402,166	B2	7/2008	Feigl	
7,416,554	B2	8/2008	Lam et al.	
7,476,196	B2 *	1/2009	Spence et al.	600/37
7,490,602	B2	2/2009	Sabri	
7,534,248	B2	5/2009	Mikkaichi et al.	
7,608,578	B2	10/2009	Miller	
7,618,426	B2	11/2009	Ewers et al.	
7,666,195	B2	2/2010	Kelleher et al.	
7,670,279	B2	3/2010	Gertner	
7,717,843	B2	5/2010	Balbierz et al.	
7,753,870	B2	7/2010	Demarais et al.	
7,775,967	B2	8/2010	Gertner	
7,824,368	B2	11/2010	Clem et al.	
7,841,978	B2	11/2010	Gertner	
7,850,660	B2	12/2010	Uth et al.	
7,862,546	B2	1/2011	Conlon et al.	
7,862,574	B2	1/2011	Deem et al.	
7,938,769	B2	5/2011	Gertner	
7,947,055	B2	5/2011	Gannoe et al.	
7,955,340	B2	6/2011	Michlitsch et al.	
7,976,555	B2	7/2011	Meade et al.	
7,988,617	B2	8/2011	Gertner	
8,001,974	B2	8/2011	Makower et al.	
8,057,490	B2	11/2011	Harris et al.	
8,152,821	B2	4/2012	Gambale et al.	
8,206,295	B2	6/2012	Kaul	
8,382,775	B1 *	2/2013	Bender et al.	606/144
2001/0010005	A1	7/2001	Kammerer et al.	
2001/0011543	A1	8/2001	Forsell	
2001/0044639	A1	11/2001	Levinson	
2001/0049497	A1	12/2001	Kalloo et al.	
2002/0055757	A1	5/2002	Torre et al.	
2002/0077660	A1	6/2002	Kayan et al.	
2002/0128684	A1	9/2002	Foerster	
2002/0161382	A1	10/2002	Neisz et al.	
2002/0161414	A1	10/2002	Flesler et al.	
2002/0188354	A1	12/2002	Peghini et al.	
2002/0198551	A1	12/2002	Grant et al.	
2003/0021822	A1	1/2003	Lloyd	
2003/0055463	A1	3/2003	Gordon et al.	
2003/0055465	A1	3/2003	Ben-Haim et al.	
2003/0093117	A1	5/2003	Saadat	
2003/0114863	A1	6/2003	Field et al.	
2003/0208212	A1	11/2003	Cigaina	
2004/0006351	A1	1/2004	Gannoe et al.	
2004/0024386	A1	2/2004	Deem et al.	
2004/0030347	A1	2/2004	Gannoe et al.	
2004/0044353	A1	3/2004	Gannoe	
2004/0044354	A1	3/2004	Gannoe et al.	
2004/0044357	A1	3/2004	Gannoe et al.	
2004/0054352	A1	3/2004	Adams et al.	
2004/0059289	A1	3/2004	Garza Alvarez	
2004/0068224	A1	4/2004	Couvillon et al.	
2004/0092892	A1	5/2004	Kagan et al.	
2004/0092967	A1	5/2004	Sancoff et al.	
2004/0097986	A1	5/2004	Adams	
2004/0098060	A1	5/2004	Ternes	
2004/0102804	A1	5/2004	Chin	
2004/0116852	A1	6/2004	Scopton	
2004/0116949	A1	6/2004	Ewers et al.	
2004/0122456	A1	6/2004	Saadat et al.	
2004/0122473	A1	6/2004	Ewers et al.	
2004/0138525	A1	7/2004	Saadat et al.	
2004/0148034	A1	7/2004	Kagan et al.	
2004/0176785	A1	9/2004	Hermann et al.	
2004/0186503	A1	9/2004	DeLegge	
2004/0193194	A1	9/2004	Laufer et al.	
2004/0194790	A1	10/2004	Laufer et al.	
2004/0210243	A1	10/2004	Gannoe et al.	
2004/0243178	A1	12/2004	Haut et al.	
2004/0243179	A1	12/2004	Foerster	
2004/0243180	A1	12/2004	Donnelly et al.	
2004/0260345	A1	12/2004	Foerster	
2004/0267378	A1	12/2004	Gazi et al.	
2005/0022827	A1	2/2005	Woo et al.	
2005/0049718	A1	3/2005	Dann et al.	
2005/0085832	A1	4/2005	Sancoff et al.	
2005/0096638	A1	5/2005	Starkebaum et al.	
2005/0159769	A1	7/2005	Alverdy	
2005/0197687	A1	9/2005	Molaei et al.	
2005/0203344	A1	9/2005	Orban, III et al.	
2005/0216040	A1	9/2005	Gertner et al.	
2005/0216042	A1	9/2005	Gertner et al.	
2005/0222638	A1	10/2005	Foley et al.	
2005/0228415	A1	10/2005	Gertner	
2005/0240222	A1	10/2005	Shipp	
2005/0240279	A1	10/2005	Kagan et al.	
2005/0250980	A1	11/2005	Swanstrom et al.	
2005/0261712	A1	11/2005	Balbierz et al.	
2005/0267405	A1	12/2005	Shah	
2005/0267406	A1	12/2005	Hassler, Jr.	
2005/0267529	A1	12/2005	Crockett et al.	
2005/0267533	A1	12/2005	Gertner	
2005/0267595	A1	12/2005	Chen et al.	
2005/0267596	A1	12/2005	Chen et al.	
2005/0273138	A1	12/2005	To et al.	
2005/0277960	A1	12/2005	Hassler, Jr. et al.	

(56) **References Cited**

U.S. PATENT DOCUMENTS

2005/0277974	A1	12/2005	Hassler, Jr. et al.
2005/0288622	A1	12/2005	Albrecht et al.
2006/0009789	A1	1/2006	Gambale et al.
2006/0020278	A1	1/2006	Burnett et al.
2006/0025783	A1	2/2006	Smith et al.
2006/0025789	A1	2/2006	Laufer et al.
2006/0025819	A1	2/2006	Nobis et al.
2006/0030867	A1	2/2006	Zadno
2006/0030884	A1	2/2006	Yeung et al.
2006/0058829	A1	3/2006	Sampson
2006/0069396	A1	3/2006	Meade et al.
2006/0089571	A1	4/2006	Gertner
2006/0089646	A1	4/2006	Bonutti
2006/0106288	A1	5/2006	Roth et al.
2006/0129094	A1	6/2006	Shah
2006/0157067	A1	7/2006	Saadat et al.
2006/0161186	A1	7/2006	Hassler, Jr. et al.
2006/0161256	A1	7/2006	Ziegler et al.
2006/0195139	A1	8/2006	Gertner
2006/0212053	A1	9/2006	Gertner
2006/0229623	A1	10/2006	Bonutti et al.
2006/0247206	A1	11/2006	Feins
2006/0253131	A1	11/2006	Wolniewicz
2006/0264699	A1	11/2006	Gertner
2006/0265042	A1	11/2006	Catanese, III et al.
2006/0276871	A1	12/2006	Lamson et al.
2006/0282081	A1	12/2006	Fanton et al.
2007/0027358	A1	2/2007	Gertner et al.
2007/0049970	A1	3/2007	Belef et al.
2007/0055095	A1	3/2007	Chu et al.
2007/0060940	A1	3/2007	Brazzini et al.
2007/0068538	A1	3/2007	Anderson et al.
2007/0073318	A1	3/2007	Carter et al.
2007/0073323	A1	3/2007	Carter et al.
2007/0078439	A1	4/2007	Grandt et al.
2007/0088362	A1	4/2007	Bonutti et al.
2007/0088373	A1	4/2007	Baker
2007/0112363	A1	5/2007	Adams
2007/0112364	A1	5/2007	Gerbi et al.
2007/0112385	A1	5/2007	Conlon
2007/0129738	A1	6/2007	Kraemer et al.
2007/0167982	A1	7/2007	Gertner et al.
2007/0173869	A1	7/2007	Gannoe et al.
2007/0173888	A1	7/2007	Gertner et al.
2007/0179335	A1	8/2007	Gertner et al.
2007/0197896	A1	8/2007	Moll et al.
2007/0198038	A1	8/2007	Cohen et al.
2007/0198074	A1	8/2007	Dann et al.
2007/0203517	A1	8/2007	Williams et al.
2007/0233161	A1	10/2007	Weller et al.
2007/0233170	A1	10/2007	Gertner et al.
2007/0235083	A1	10/2007	Dlugos
2007/0239284	A1	10/2007	Skerven et al.
2007/0250103	A1	10/2007	Makower et al.
2007/0250112	A1	10/2007	Ravikumar et al.
2007/0255308	A1	11/2007	Williams et al.
2007/0260259	A1	11/2007	Fanton et al.
2007/0270892	A1	11/2007	Makower et al.
2007/0276293	A1	11/2007	Gertner
2007/0276432	A1	11/2007	Stack
2008/0009888	A1	1/2008	Ewers et al.
2008/0015501	A1	1/2008	Gertner
2008/0033488	A1	2/2008	Catanese, III et al.
2008/0039894	A1	2/2008	Catanese, III et al.
2008/0051823	A1	2/2008	Makower et al.
2008/0051824	A1	2/2008	Gertner
2008/0051850	A1	2/2008	Sparks et al.
2008/0058710	A1	3/2008	Wilk
2008/0071306	A1	3/2008	Gertner
2008/0082113	A1	4/2008	Bishop et al.
2008/0086082	A1	4/2008	Brooks
2008/0086172	A1	4/2008	Martin et al.
2008/0091220	A1	4/2008	Chu
2008/0091237	A1	4/2008	Schwartz et al.
2008/0109027	A1	5/2008	Chen et al.
2008/0147002	A1	6/2008	Gertner
2008/0161717	A1	7/2008	Gertner
2008/0167519	A1	7/2008	St-Germain
2008/0167647	A1	7/2008	Gertner
2008/0167648	A1	7/2008	Gertner
2008/0172074	A1	7/2008	Baker et al.
2008/0172079	A1	7/2008	Birk
2008/0208240	A1	8/2008	Paz
2009/0005633	A9	1/2009	Montpetit et al.
2009/0012538	A1	1/2009	Saliman et al.
2009/0018552	A1	1/2009	Lam et al.
2009/0023984	A1	1/2009	Stokes et al.
2009/0024144	A1	1/2009	Zeiner et al.
2009/0072006	A1	3/2009	Clauson et al.
2009/0082792	A1	3/2009	Koyfman et al.
2009/0093850	A1	4/2009	Richard
2009/0149879	A1	6/2009	Dillon
2009/0192531	A1	7/2009	Hsu et al.
2009/0198254	A1	8/2009	Laufer et al.
2009/0270856	A1	10/2009	Saadat et al.
2009/0275942	A1	11/2009	Ortiz et al.
2009/0287227	A1	11/2009	Newell et al.
2010/0130998	A1	5/2010	Alverdy
2010/0145324	A1	6/2010	Nihalani
2010/0145370	A1	6/2010	Nihalani
2011/0009896	A1	1/2011	Forsell
2011/0172767	A1	7/2011	Rathi et al.
2011/0174864	A1	7/2011	Cole et al.
2011/0178454	A1	7/2011	Gagner et al.
2011/0196411	A1	8/2011	Forsell
2011/0208209	A1	8/2011	Ewers et al.
2011/0257760	A1	10/2011	Waldrep
2011/0295056	A1	12/2011	Aldridge
2011/0295057	A1	12/2011	Aldridge
2012/0041463	A1	2/2012	Forsell
2012/0059396	A1	3/2012	Harris et al.
2012/0143247	A1	6/2012	Smith et al.
2012/0149975	A1	6/2012	Cohen
2012/0150176	A1	6/2012	Weizman
2012/0165602	A1	6/2012	Nissen

FOREIGN PATENT DOCUMENTS

EP	1261282 B1	3/2001
EP	1 602 392	7/2005
EP	1 591 140	11/2005
EP	1 520 563	4/2006
EP	1 547 642	8/2007
EP	1 607 071	8/2007
EP	1 884 198	2/2008
EP	1 670 361	4/2008
FR	2 907 665	5/2008
WO	WO 87/00034	1/1987
WO	WO 99/25418	5/1999
WO	WO 00/09049	2/2000
WO	WO 00/18330	4/2000
WO	WO 00/74573	12/2000
WO	WO 01/47435	7/2001
WO	WO 02/35980	5/2002
WO	WO 02/071951	9/2002
WO	WO 03/055420	7/2003
WO	WO 03/095015	11/2003
WO	WO 2004/004542	1/2004
WO	WO 2004/014237	2/2004
WO	WO 2004/019765	3/2004
WO	WO 2004/021894	3/2004
WO	WO 2004/037064	5/2004
WO	WO 2004096057	11/2004
WO	WO 2005/007232	1/2005
WO	WO 2005/009288	2/2005
WO	WO 2005/018417	3/2005
WO	WO 2005/020802	3/2005
WO	WO 2005/094447	10/2005
WO	WO 2005/105003	11/2005
WO	WO 2006/002192	1/2006
WO	WO 2006/020370	2/2006
WO	WO 2006/049725	5/2006
WO	WO 2006/063593	6/2006
WO	WO 2006/093975	9/2006

(56) **References Cited**

FOREIGN PATENT DOCUMENTS

WO	WO 2006/108203	10/2006
WO	WO 2006/127431	11/2006
WO	WO 2006/134106	12/2006
WO	WO 2007/017880	2/2007
WO	WO 2007/064906	6/2007
WO	WO 2007/067206	6/2007
WO	WO 2007/067919	6/2007
WO	WO 2007/110866	10/2007
WO	WO 2008/006084	1/2008
WO	WO 2008/013814	1/2008
WO	WO 2008/043044	4/2008
WO	WO 2010/087756	8/2010
WO	WO 2011/149882	12/2011

OTHER PUBLICATIONS

Akira., JP63277063, Japanese and English Abstract, Nov. 15, 1988, pp. 1-4.

Abhyankar et al, Use of a tissue expander and a polyglactic acid (Vicryl) mesh to reduce radiation enteritis: case report and literature view, Pediatr. Surg. Int. 21: pp. 755-757, Aug. 2005.

Buchwald, Overview of Bariatric Surgery, J. Amer. College of Surgeons,vol. 194, No. 3, Mar. 2002, pp. 367-375.

Buchwald et al., "Bariatric Surgery: A Systematic Review and Meta-analysis", JAMA 2004, vol. 292, No. 14, pp. 1724-1737.

Buchwald et al., "Evolution of Operative Procedures for the Management of Morbid Obesity 1950-2000", Obesity Surgery 2002, 12:705-717.

Burnett, et al., The Use of a Pelvic Displacement Prosthesis to Exclude the Small Intestine from the Radiation Field Following Radical Hysterectomy, Gynecologic Oncology,79, pp. 438-443, 2000. http://www.idealibrary.com.

Brolin, Robert E., Gastric Bypass. Obesity Surgery, vol. 81, No. 5, Oct. 2001, pp. 1077-1095.

Brethauer, et al. "Laparoscopic gastric plication for treatment of severe obesity", American Society for Metabolic and Bariatric Surgery, 2010, pp. 1-8.

Brethauer, et al. "Laparoscopic Greater Curvature plication in the canine: comparison of durability and tissue response using fasteners and suture", Abstracts: Poster Session 2011 / Surgery for Obesity and Related Diseases, 7 (2011) pp. 400-401.

Cheng, Splenic Epidermoid Cyst, pp. 1-3, 1997.

Camerini et al., "Thirteen Years of Follow-up in Patients with Adjustable Silicone Gastric Banding for Obesity: Weight Loss and Constant Rate of Late Specific Complications" Obesity Surgery 2004, 14:1343-1348.

Cope et al., "Percutaneous Transgastric Technique for Creating Gastroenteric Anastomoses in Swine", Journal of Vascular and Interventional Radiology, 2004, 15:177-181.

Conroy, et al. Lubricious Coatings for Medical Devices. dds&s, vol. 3, No. 4, Jan. 2004, pp. 89-92.

Cottam, "Gastric Imbrication: The Future or Fantasy?", General Surgery News, Jul. 2011, vol. 38:7, pp. 1-5.

Cummings et al., "Genetics and Pathophysiology of Human Obesity", An Annual Review of Medicine, 2003, 54:453-471/.

DeMaria, Eric J., Laparoscopic Adjustable Silicone Gastric Banding. Obesity Surgery,vol. 81, No. 5, Oct. 2001, pp. 1129-1143.

Deitel,Mervyn., Overview of Operations for Morbid Obesity. World J. Surg., vol. 22, No. 9, Sep. 1998, pp. 913-918.

Doherty, Cornelius., Technique of Vertical Banded Gastroplasty. Obesity Surgery, vol. 81, No. 5, Oct. 2001, pp. 1097-1111.

Fried et al., Physical Principles of Available Adjustable Gastric Bands: How they Work. Obesity Surgery, 14, 2004, pp. 1118-1121.

Foglia et al., Management of giant omphalocele with rapid creation of abdominal domain, J. Ped. Surg., 41, pp. 704-709, 2006.

Geliebter et al; Extra-abdominal pressure alters food intake, intragastric pressure, and gastric emptying rate. Amer. Phys. Soc., 1986, pp. R549-R552.

Gertner, Stomach Restriction with an Extragastric Balloon, pp. 1, Abstract for 2007.

Goel et al., "Reversal of gastric plication after laparoscopic adjustable gastric banded plication" Surgery for Obesity and Related Diseases, 2011, pp. 1-2.

Hainaux et al., Laparoscopic adjustable silicone gastric banding: radiological appearances of a new surgical treatment for morbid obesity. 1999, Abdom Imaging 24: 533-537.

Hoffman et al., Morbidity after Intraperitoneal Insertion of Saline-Filled Tissue Expanders for Small Bowel Exclusion from Radiotherapy Treatment Fields: A Prospective Four Year Experience with 34 Patients, The American Surgeon, pp. 473-483, No. 7, vol. 60, Jul. 1994.

Huang, et al., "Novel bariatric technology: laparoscopic adjustable gastric banded plication: technique and preliminary results", Surgery for Obesity and Related Diseases, 8 (2012), pp. 41-47.

Johnston et al., "The Magenstrasse and Mill Operation for Morbid Obesity", Obesity Surgery 2003, 13:10-16.

Konturek et al., Neuro-Hormonal Control of Food Intake; Basic Mechanisms and Clinical Implications, J. Phys. And Pharma., 2005, 56, Supp 6, 5-25. www.jpp.krakow.pl.

Kirk, "An Experimental Trial of Gastric Plication as a Means of Weight Reduction in the Rat", Brit. J. Surg., 1969, vol. 56, No. 12, pp. 930-933.

Lam et al., Huge Splenic Epidemoid Cyst: A Case Report, Chin Med J, 1997; 60:113-6.

Laparoscopic Duodenal Switch, Mar. 24, 2006, http://wo-pub2.med.cornell.edu/chi.bin/WebObjects/PublicA.woa/5/w . . . p. 1-1.

Lee et al.,"Laparoscopic Vertical Sleeve Gastrectomy: A Novel Bariatric Procedure-superior to Established Operations?" pp. 1-27. 90.sup.th Annual Clinical Congress, New Orleans, LA, Oct. 10, 2004.

Lopez-Corvala, et al., "Gastric placation: Our experience in 100 patients", Abstracts: Plenary Session 2011 / Surgery for Obesity and Related Diseases, 7 (2011) , pp. 350-351.

LGCP, presentation Cleveland Clinic, Oct. 22, 2011.

Med-4840, Product Profile , Mar. 30, 2007, pp. 1-2.

Malassagne, et al., "Intra-abdominal Sengstaken-Blakemore tube Placement for acute venous outflow obstruction in reduced-size Liver", British J. Surg., Nov. 1996, 83, pp. 1086.

Marceau, et al., "Malabsorptive Obesity Surgery.", Obesity Surgery, vol. 81, Oct. 2001, No. 5, pp. 1113-1127.

McMillan, et al., "Arthroscopic Knot-tying techniques", An Atlas of Shoulder Arthroscopy, pp. 81-95, 2003.

Mera, et al., Use of the Breast Implant for Liver Graft Malposition. Liver Transp. And Surg., vol. 5, No. 6, Nov. 1999, pp. 534-535.

Menchaca et al., "Gastric Plication: Preclinical study of durability of serosa-to-serosa apposition", Surgery for Obesity and Related Diseases, 7 (2011), pp. 8-14.

Morino et al., "Laparoscopic Adjustable Silicone Gastric Banding Versus Vertical Banded Gastroplasty in Morbidly Obese Patients" Analysis Obesity Surgery vol. 238, No. 6, 2003, pp. 835-842.

Obesity Surgery Including Laparoscopy and Allied Care. vol. 16, No. 1, Jan. 2006, pp. 1-2. www.obesitysurgey.com.

Ong'uti, et al., "Effective weight loss management with endoscopic gastric plication using StomaphyX device: is it achievable?", Surgery for Obesity and Related Diseases, 2011, pp. 1-5.

Ramos et al., "Laparoscopic Greater Curvature Plication: Initial Results of an Alternative Restrictive Bariatric Procedure", Obes. Surg., Apr. 21, 2010, pp. 913-918.

Pomerri et al., Adjustable Silicone Gastric Banding of Obesity. , 1992, Gastrointest Radiol 17: pp. 207-210.

Roman et al., "Intragastric Balloon of Non-Morbid Obesity: A Retrospective Evaluation of Tolerance and Efficacy", Obesity Surgery, 2004, 14:539-544.

Sallet et al., Brazilian Multicenter Study of the Intragastric Balloon; Obesity Surgery, 2004, 14, pp. 991-998.

Sharp, et al., The 4-S Modification of the Roeder Knot: How to Tie It. Obstetrics and Gyn., pp. 1004-1006, vol. 90, No. 6, Dec. 1997.

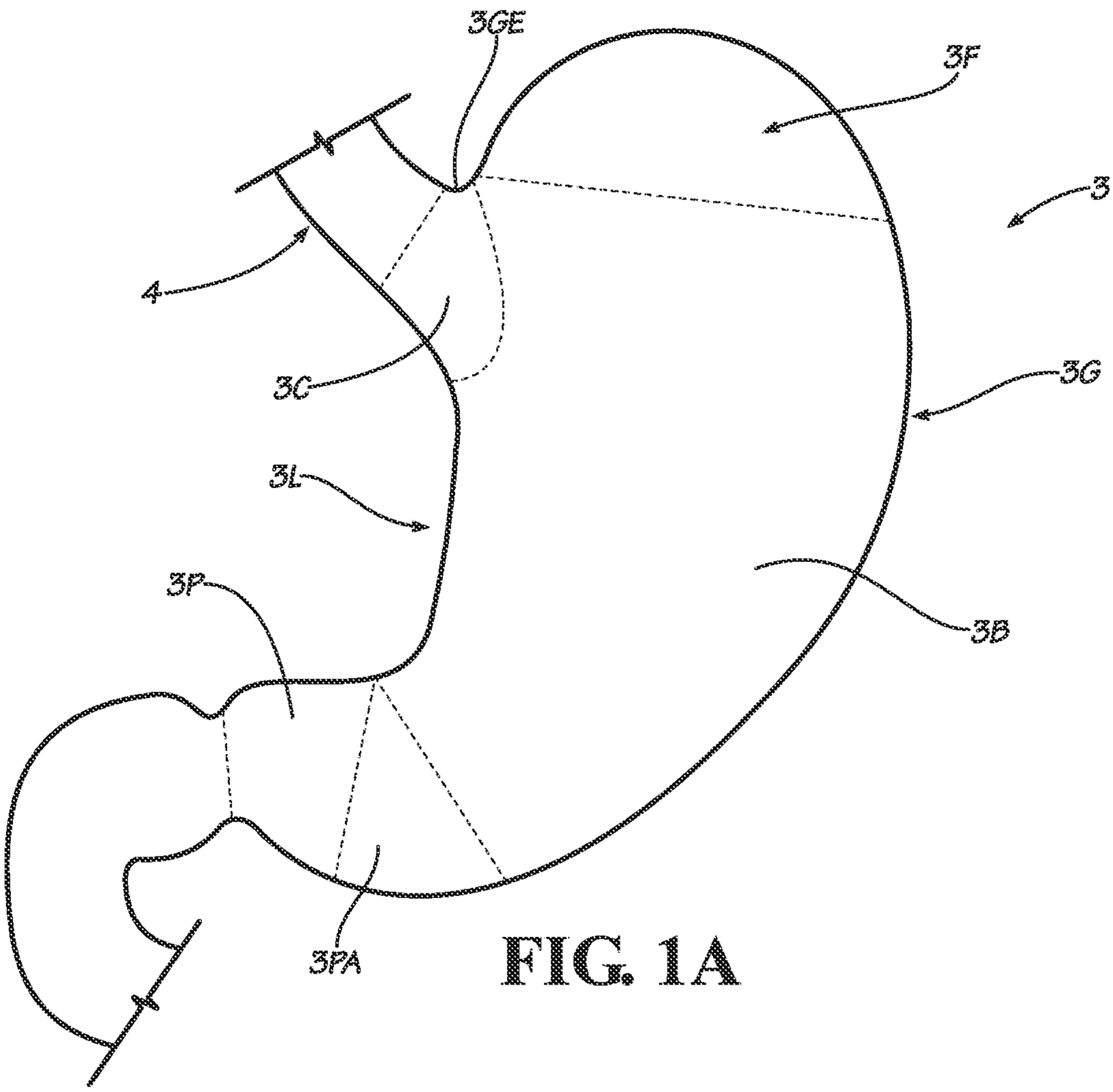
Sjostrom et al., Lifestyle, Diabetes, and Cardiovascular Risk Factors 10 years after Bariatric Surgery, New England Journal of Medicine, 2004, 351, (6) 2683-2693.

Schauer, et al., New applications for endoscopy: the emerging field of endoluminal and transgastric bariatric surgery, DOI:10.1007/s00464-006-9008-8, 2006.

(56) **References Cited**

OTHER PUBLICATIONS

Skrekas, et al., "Laparoscopic Gastric Greater Curvature Plication: Results and Complications in a Series of 135 Patients", Obes. Surg. (2011) pp. 1657-1663.
Smith et al., "Modification of the Gastric Partitioning Operation for Morbid Obesity", Am. J. Surgery 142, Dec. 1981.pp. 725-730.
Smith et al., "Results and Complications of Gastric Partitioning: Four Years Follow-Up of 300 Morbidly Obese Patients", The American Journal of Surgery, 1983, (146) pp. 815-819.
Talebpour, et al., "Laparoscopic Total Gastric Vertical Plication in Morbid Obesity", Journal of Laparoendoscopic & Advanced Surgical Techniques, vol. 17, No. 6, 2007, pp. 793-798.
The Sleeve Gastrectomy (or 2-Stage Procedure). 2006, pp. 1-2. http://surgicallyslim.com/sleeve.htm.
Trumble et al., "Method for measuring long-term function of muscle-powered implants via radiotelemetry" J. Appl. Physiol. 2001,90: pp. 1977-1985.
Tucker, Diana, Medical Device Daily. vol. 10, No. 102, pp. 1-10, May 26, 2006.
von Renteln et al., "Endoscopic full-thickness plication for the treatment of gastroesophageal reflux disease using multiple Plicator implants: 12-month multicenter study results", Surg. Endosc. (2009) 23: 1866-1875.
Walker, et al. Bladder Augmentation in Dogs Using the Tissue Capsule Formed Around a Perivesical tissue Expander, J. Urology, vol. 168, pp. 1534-1536, 2002.
Watkins, "Gastric compartment syndrome: an unusual complication of gastric plication surgery", Surgery for Obesity and Related Diseases, (2011), pp. 1-2.
Zwart et al., "Gastric Motility: Comparison of Assessment with Real-Time MR Imaging or Barostat Experience", Radiology, 224: pp. 592-597, Aug. 2002.
International Search Report and Written Opinion for PCT/US2013/020598, 2013.
* cited by examiner



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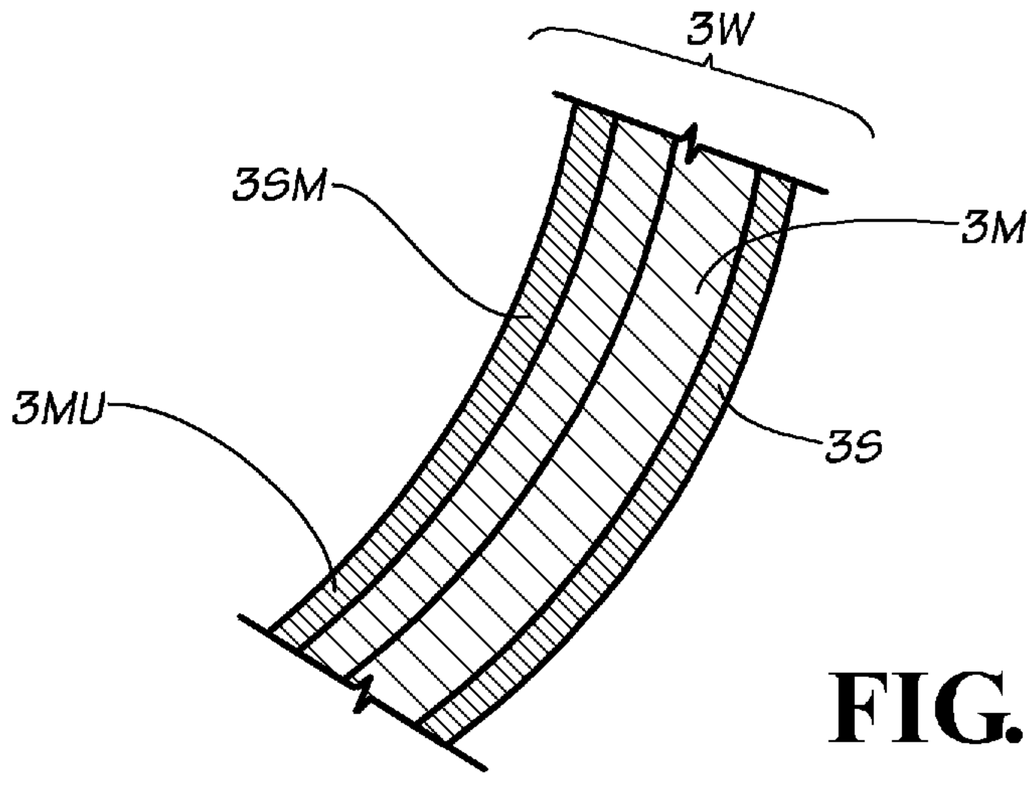

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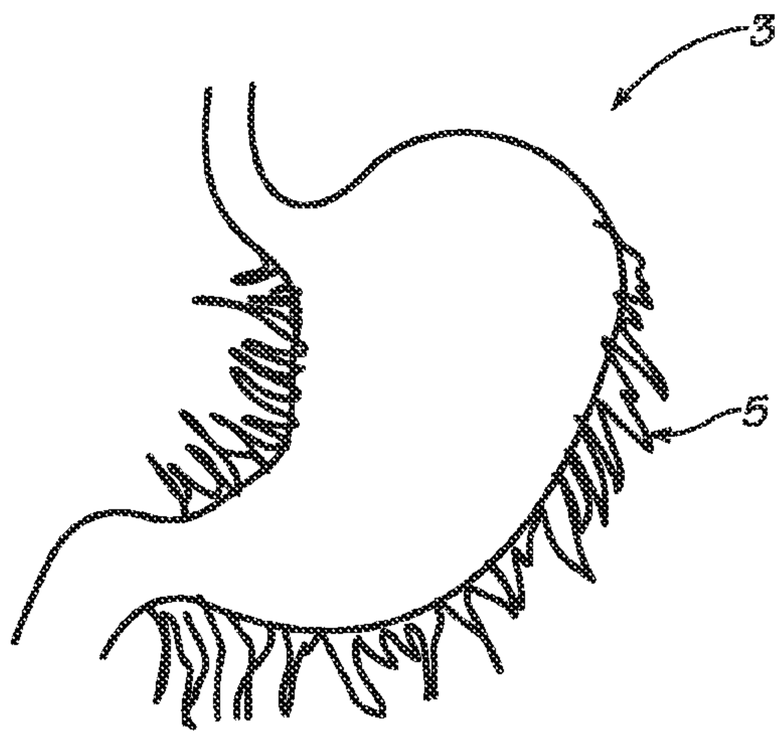

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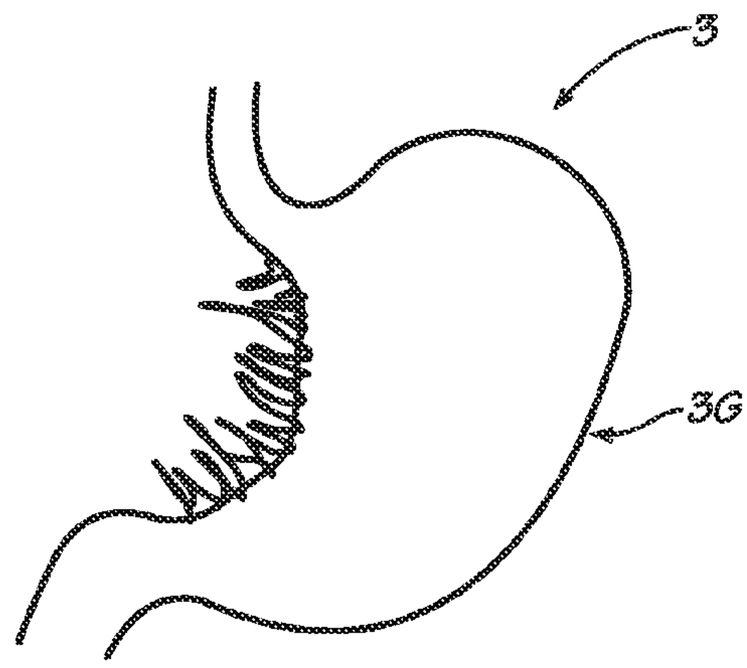

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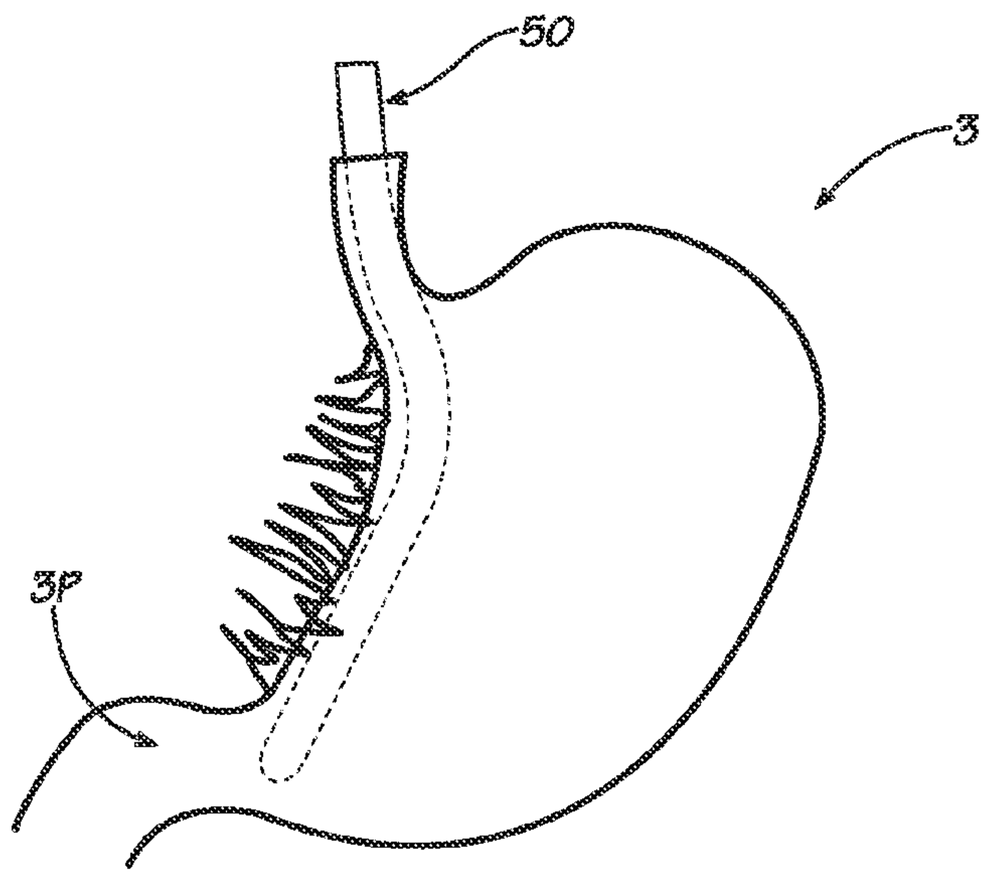


FIG. 2C

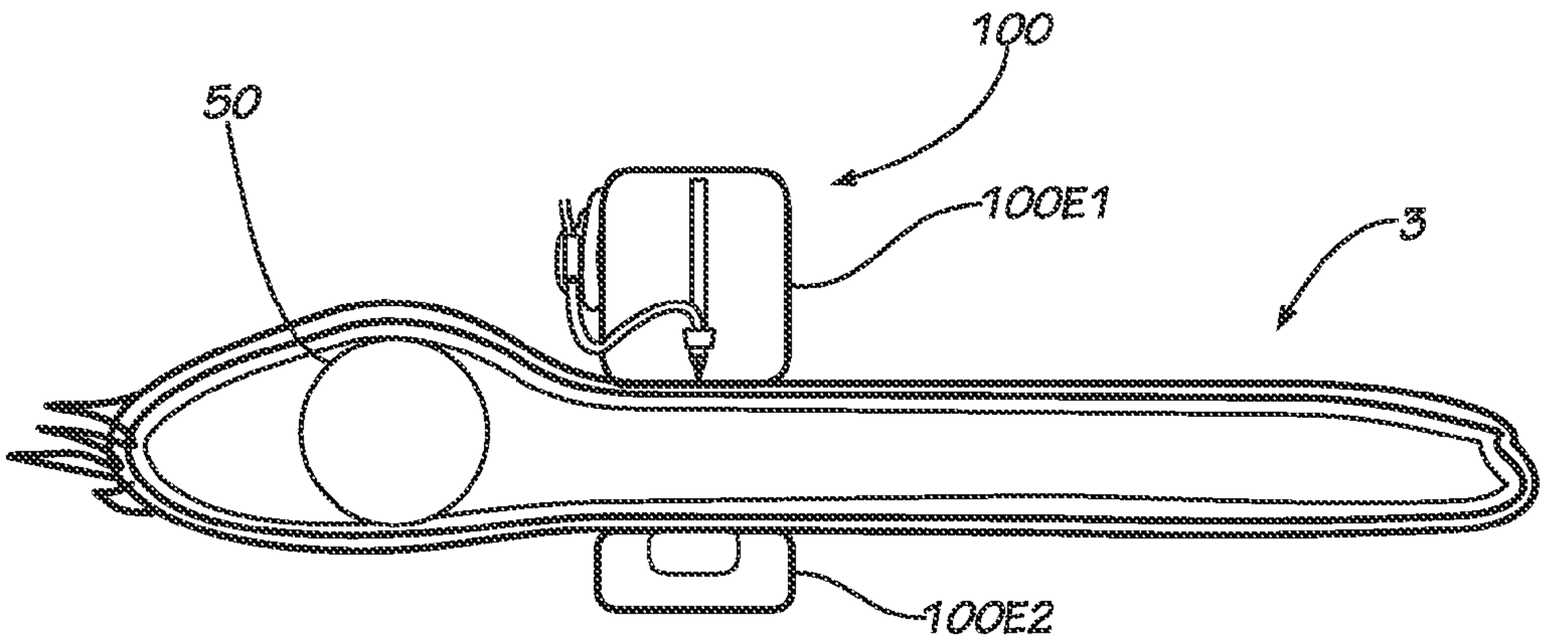


FIG. 2D

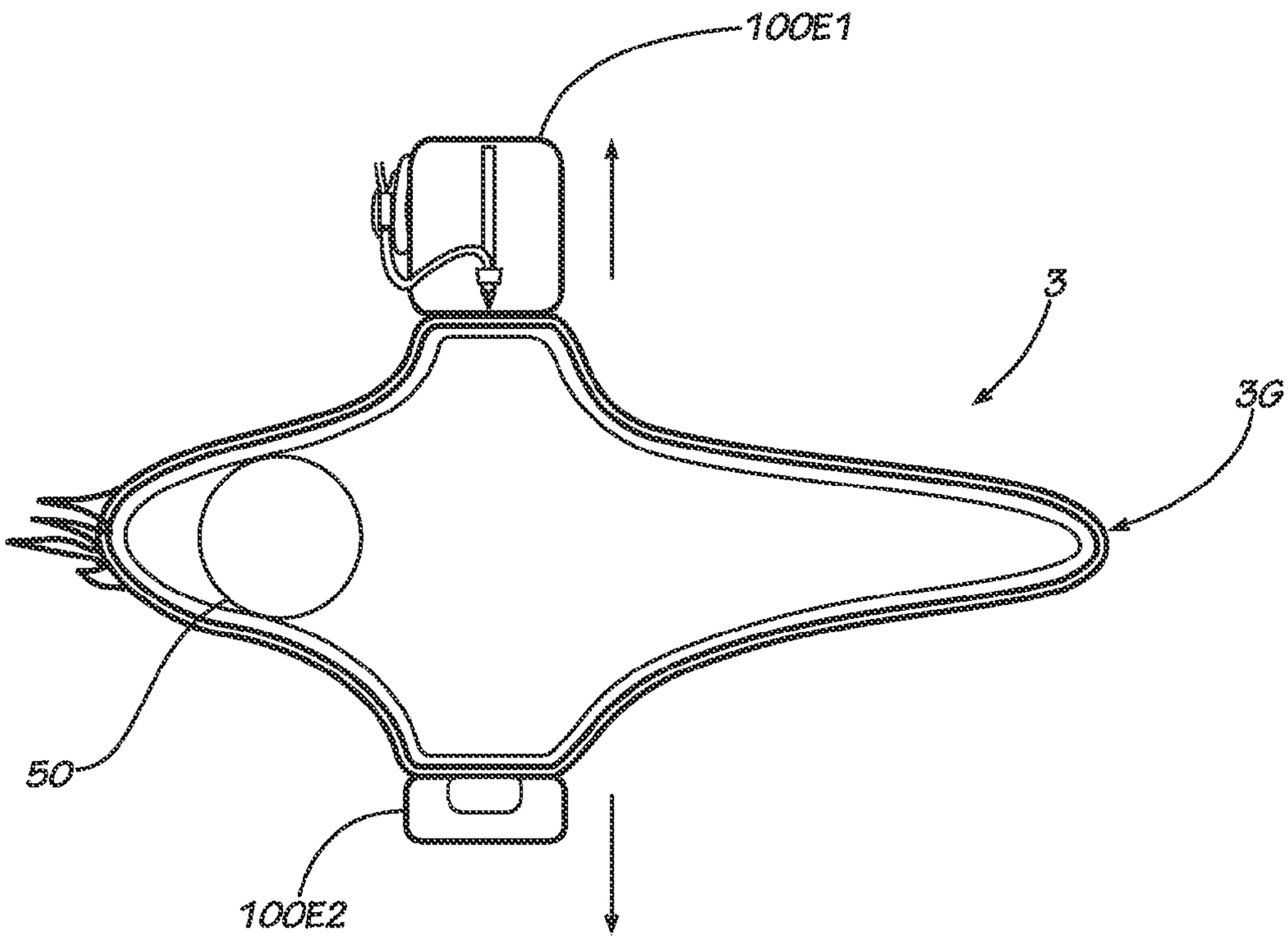


FIG. 2E

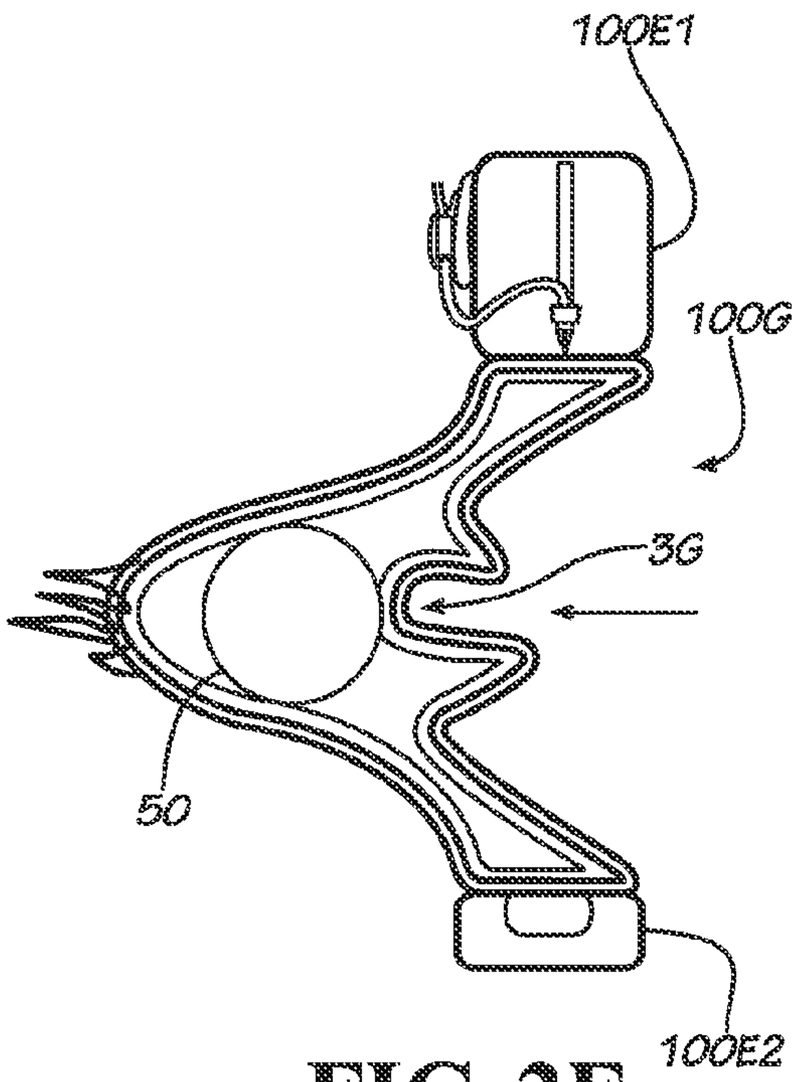


FIG. 2F

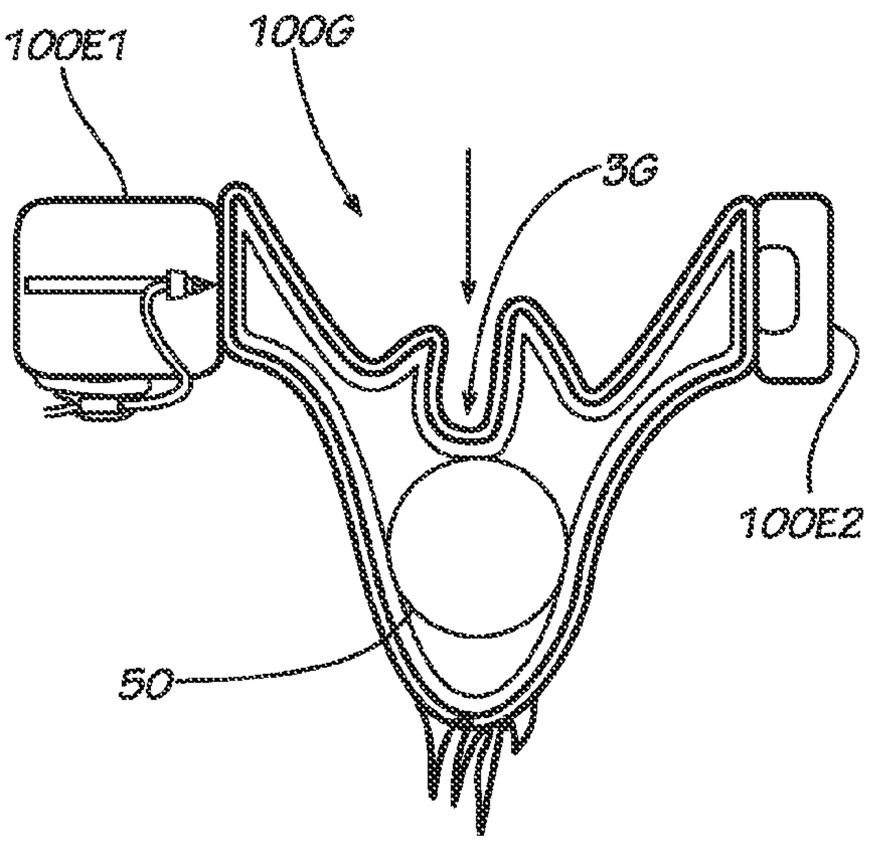


FIG. 2F'

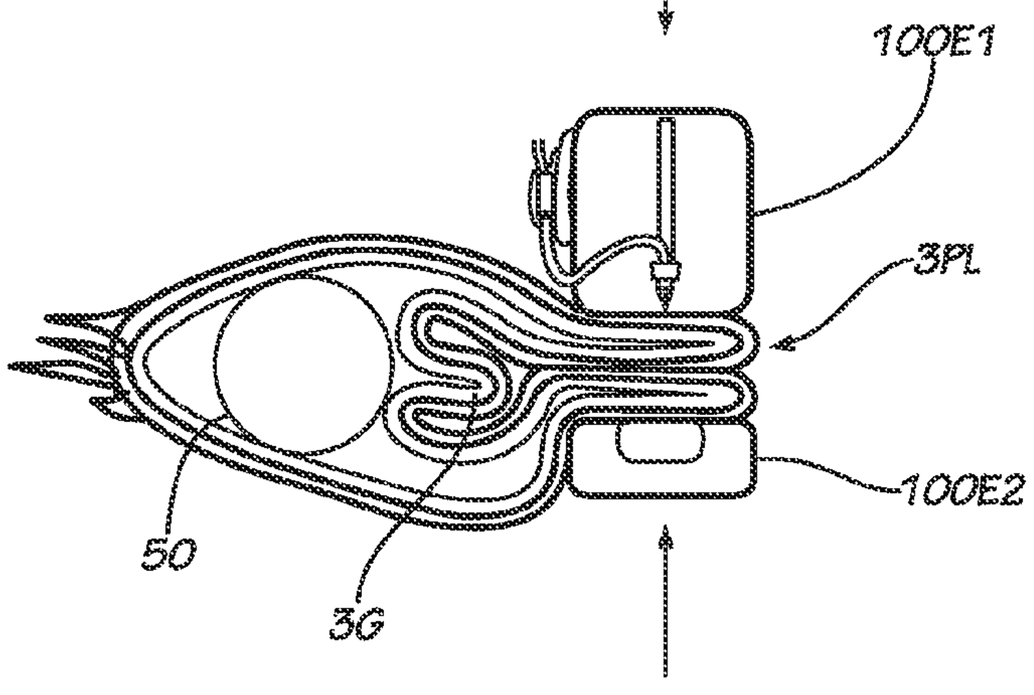
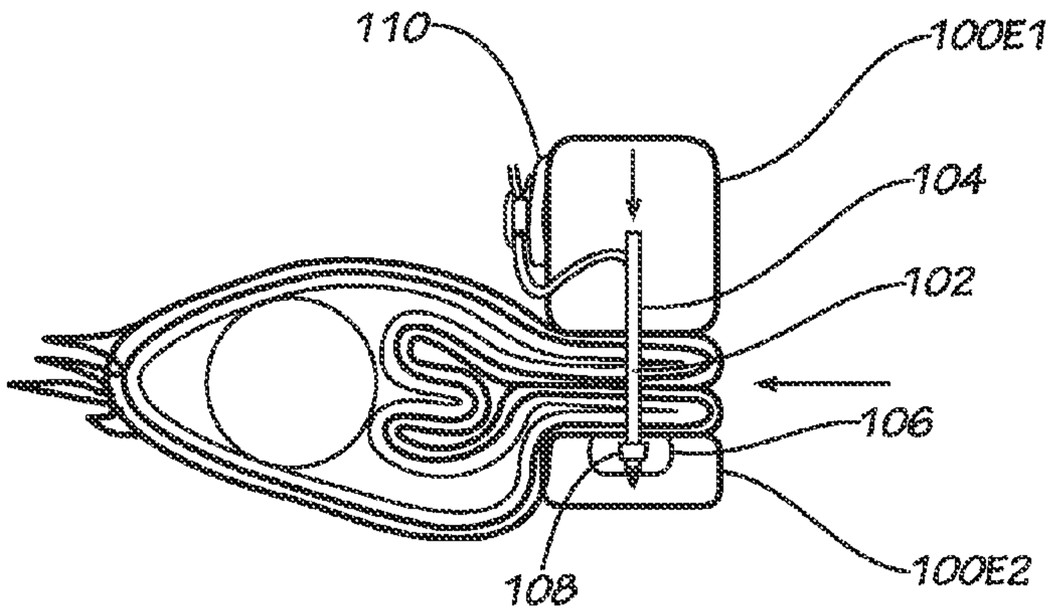


FIG. 2G



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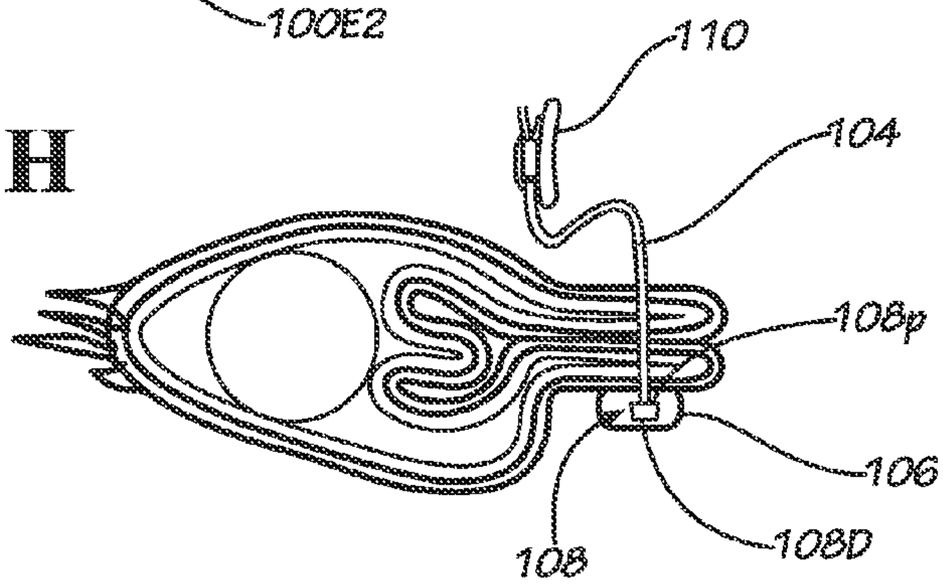
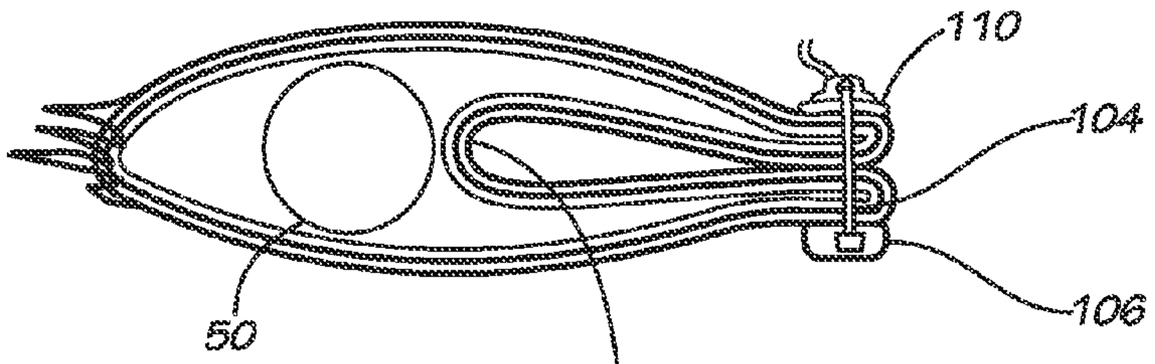


FIG. 2I



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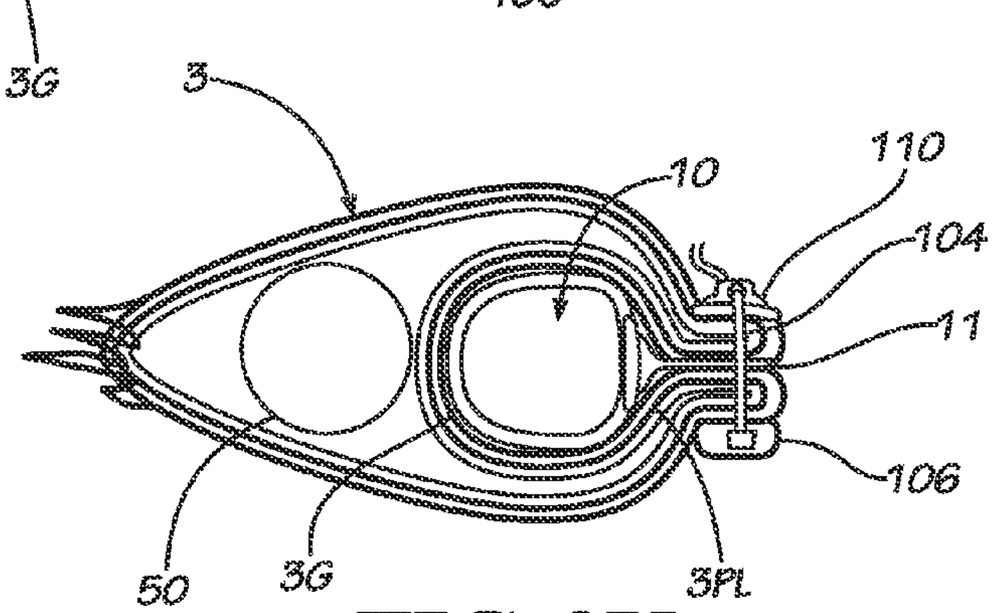

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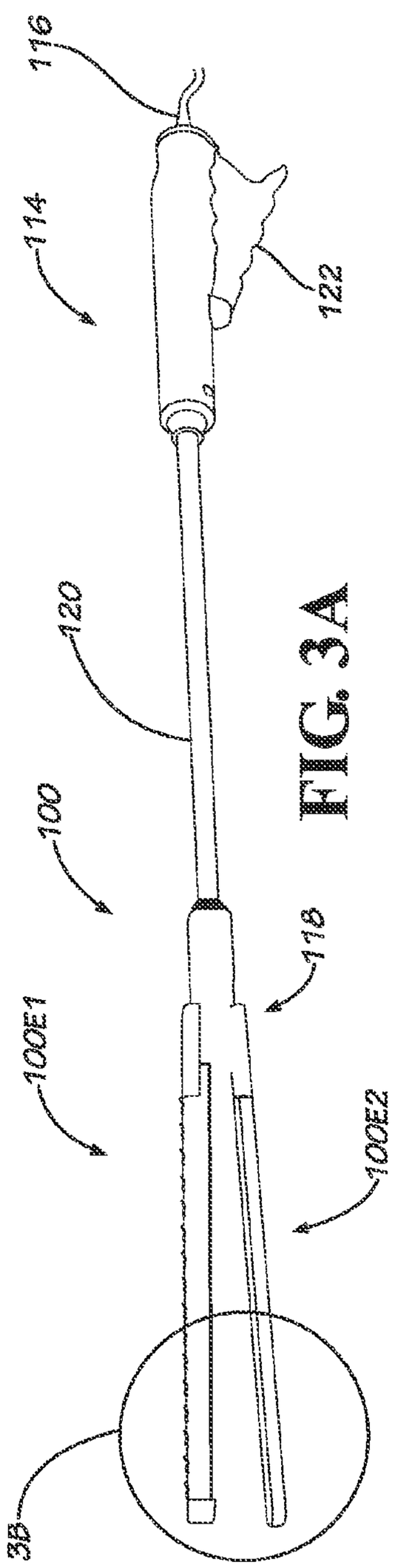

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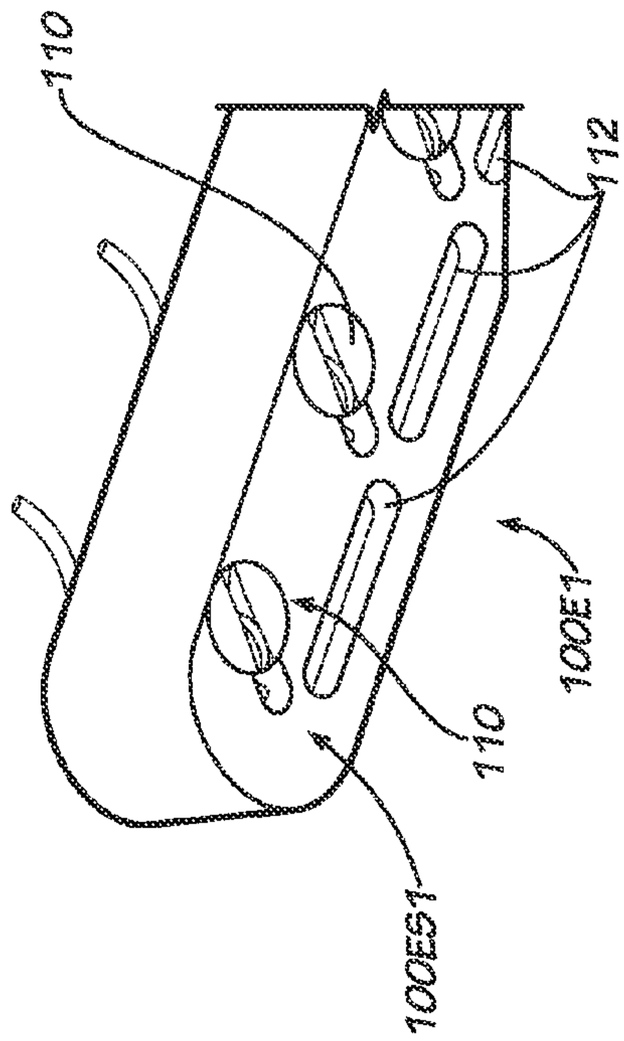

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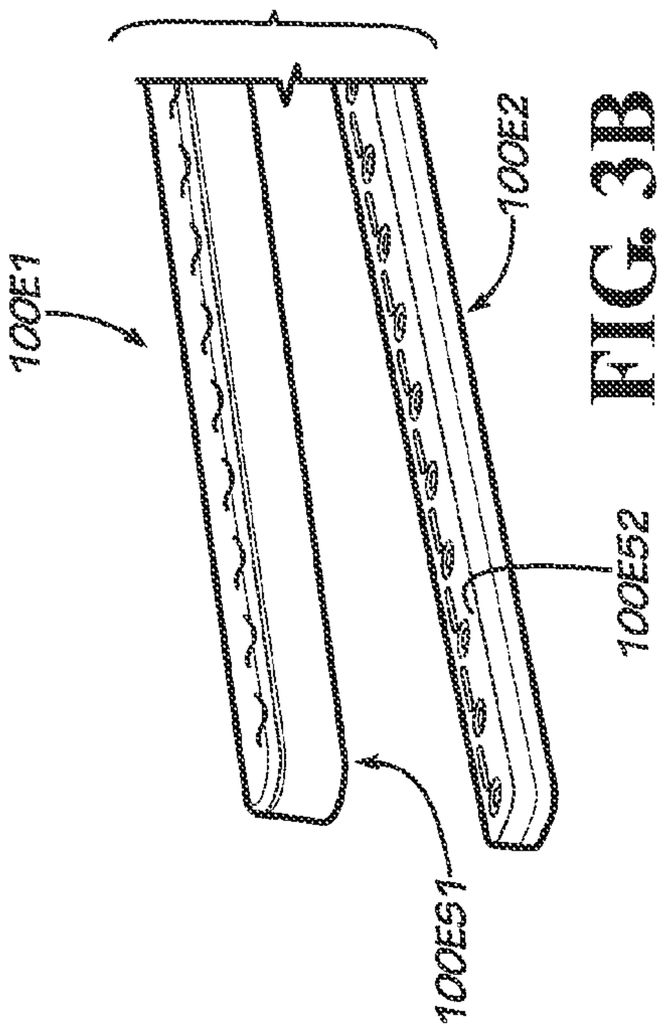

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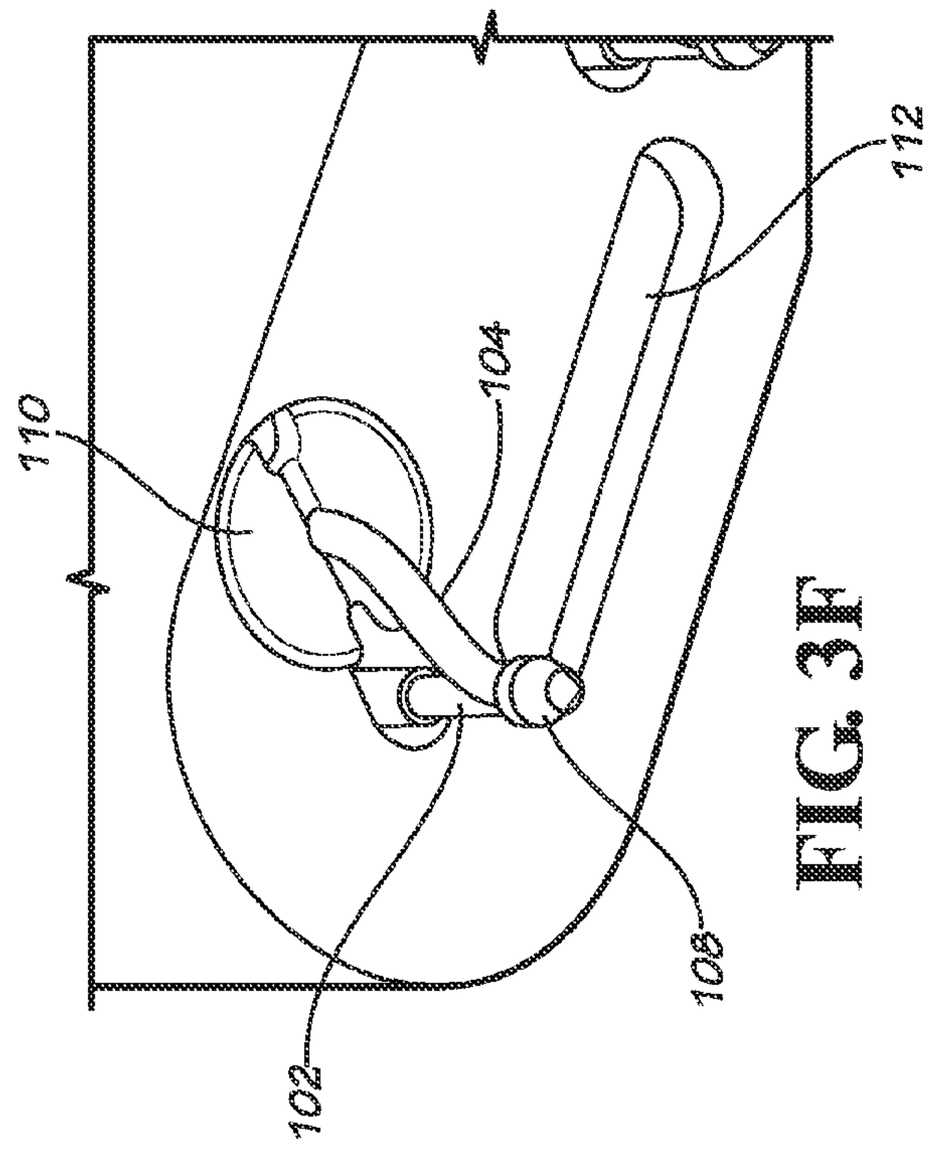

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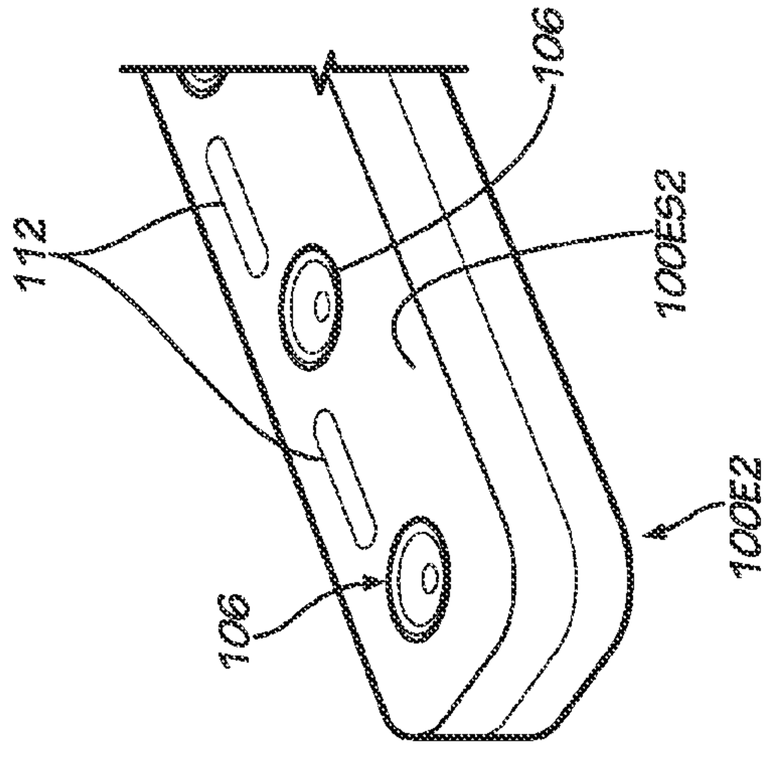
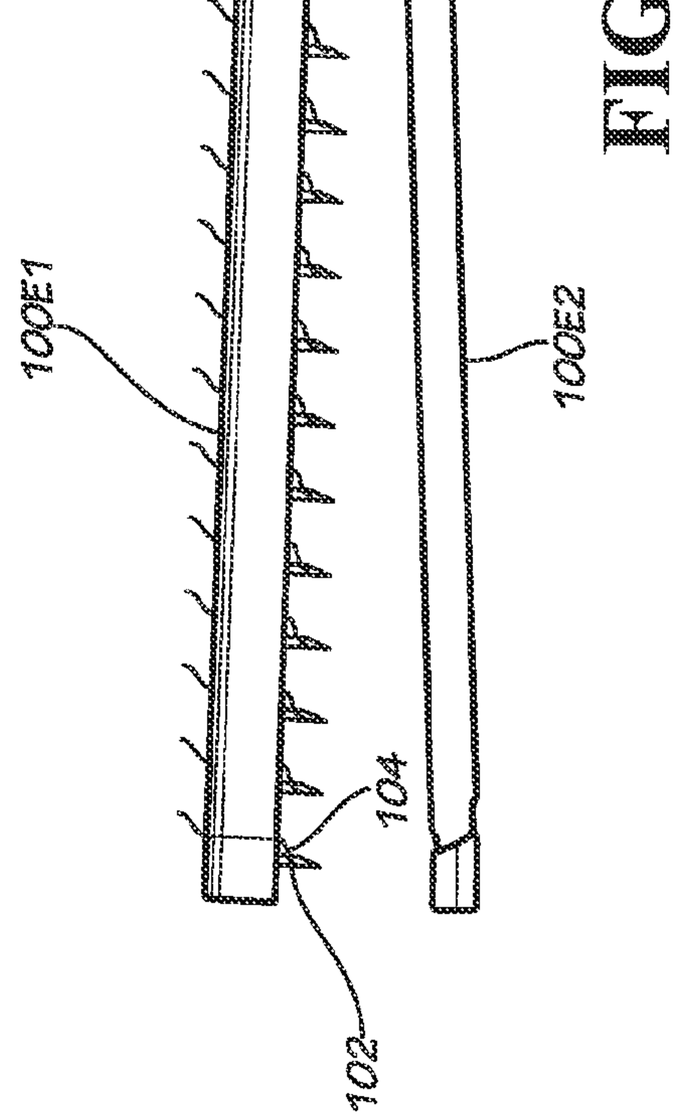


FIG. 3D



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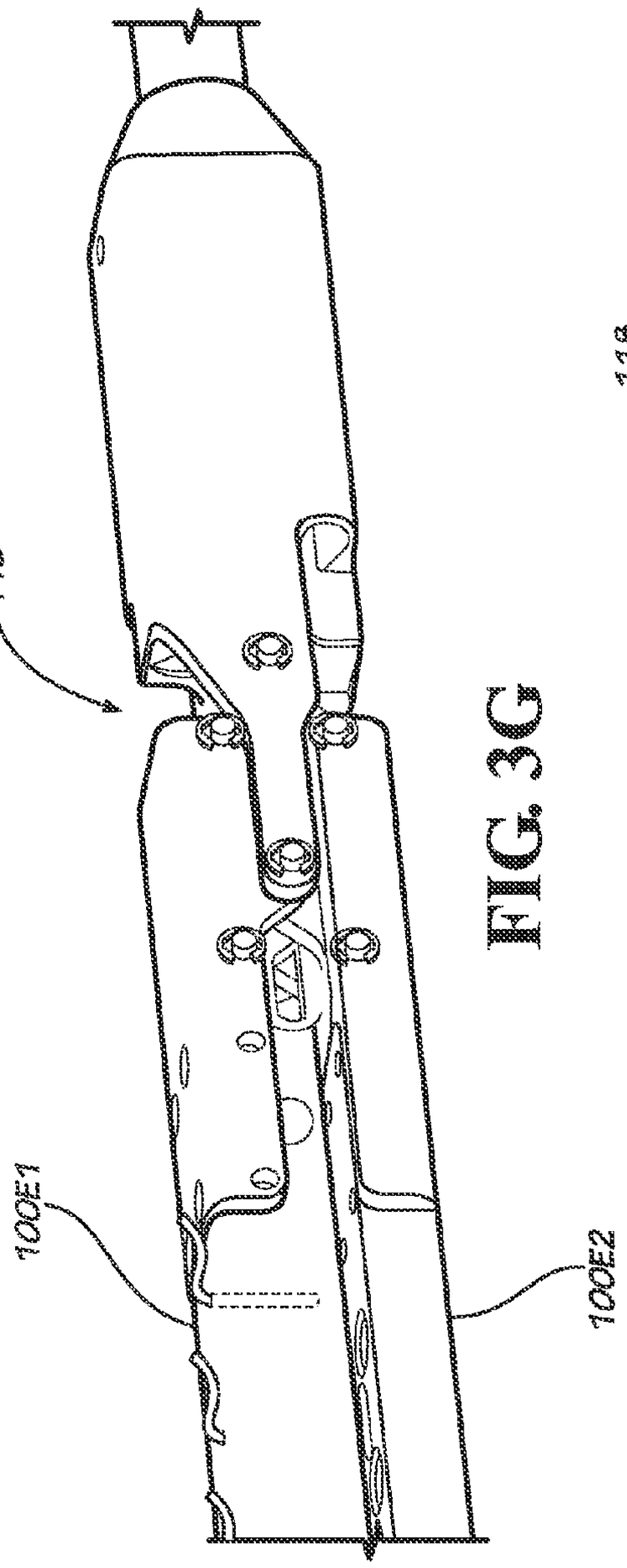

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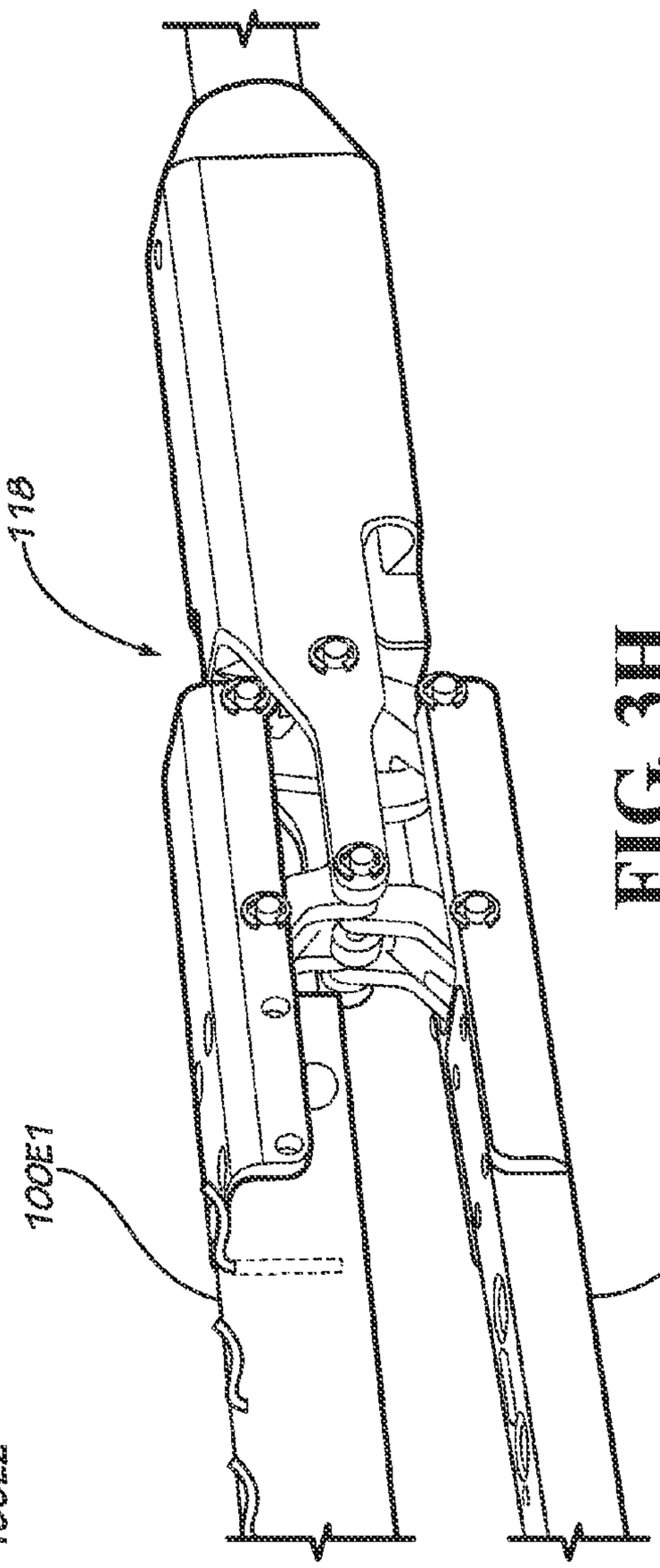

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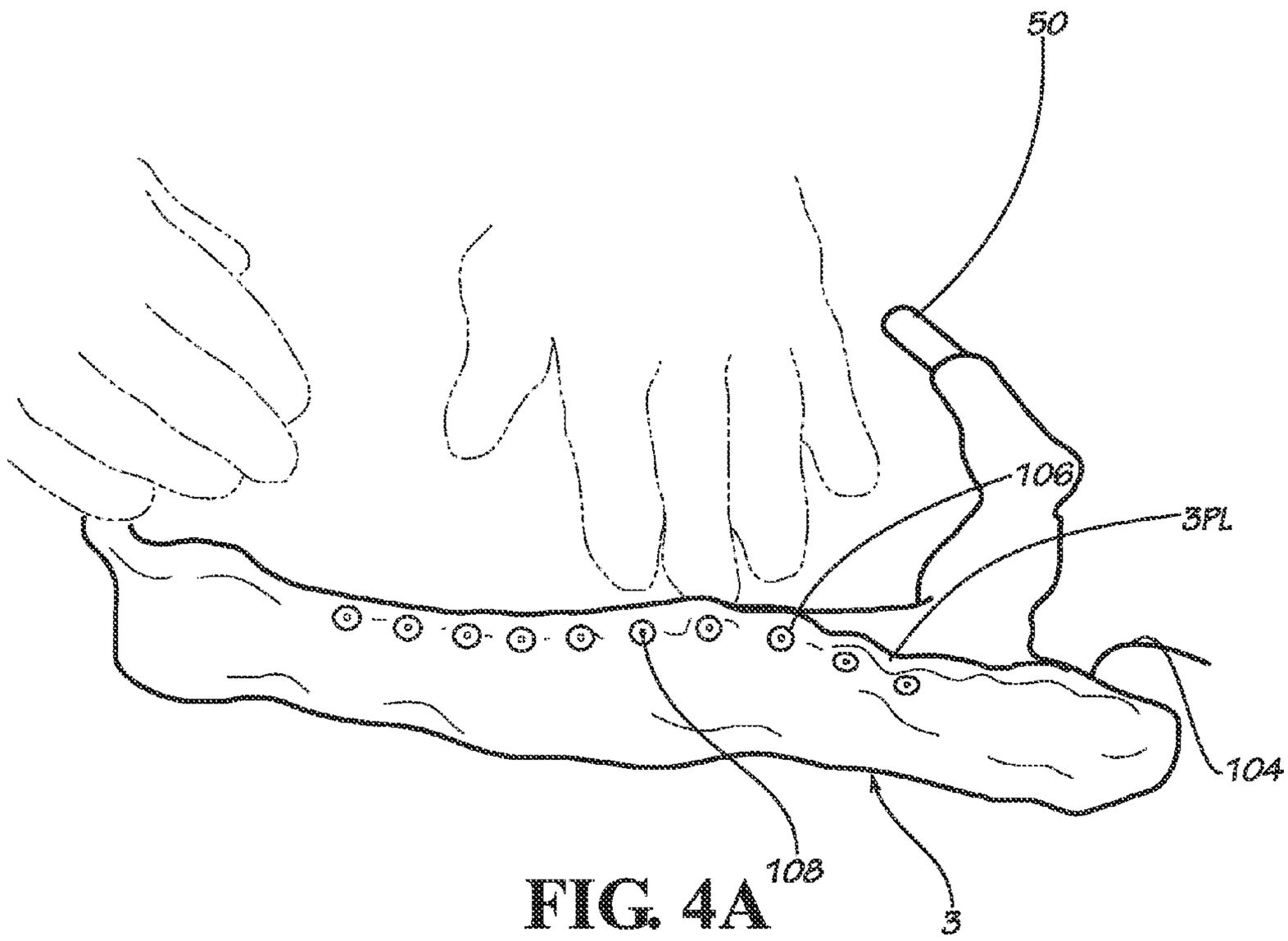


FIG. 4A

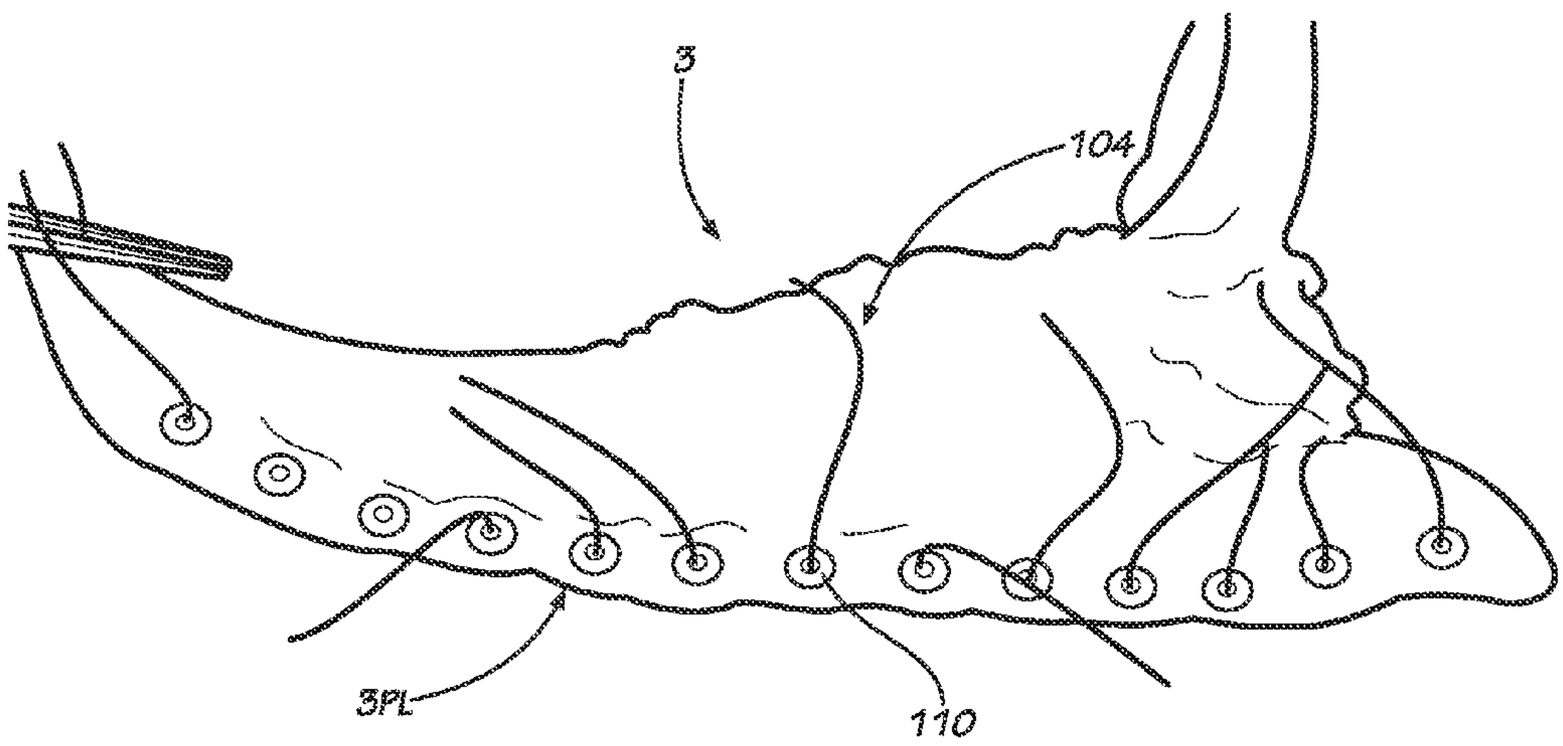


FIG. 4B

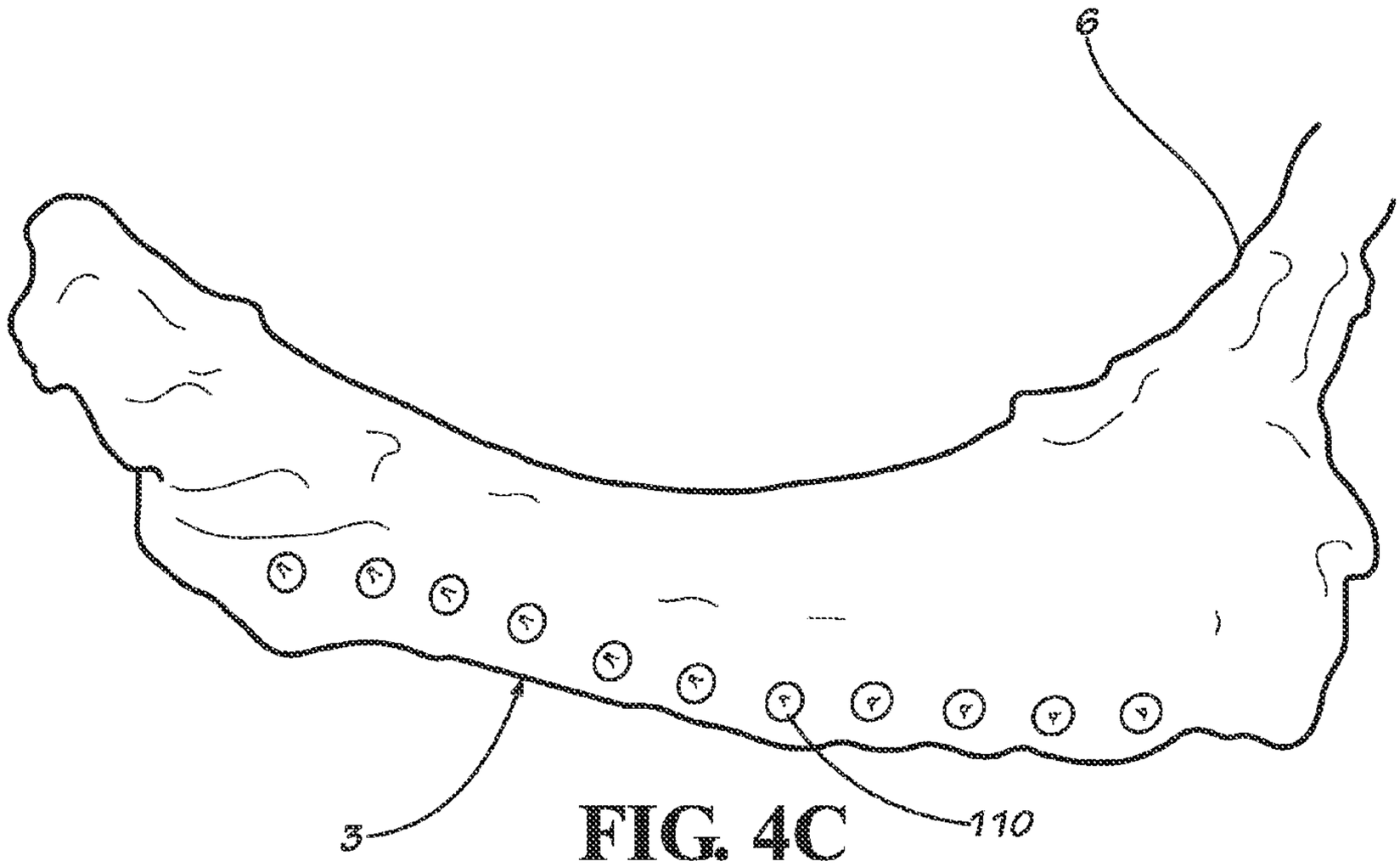


FIG. 4C

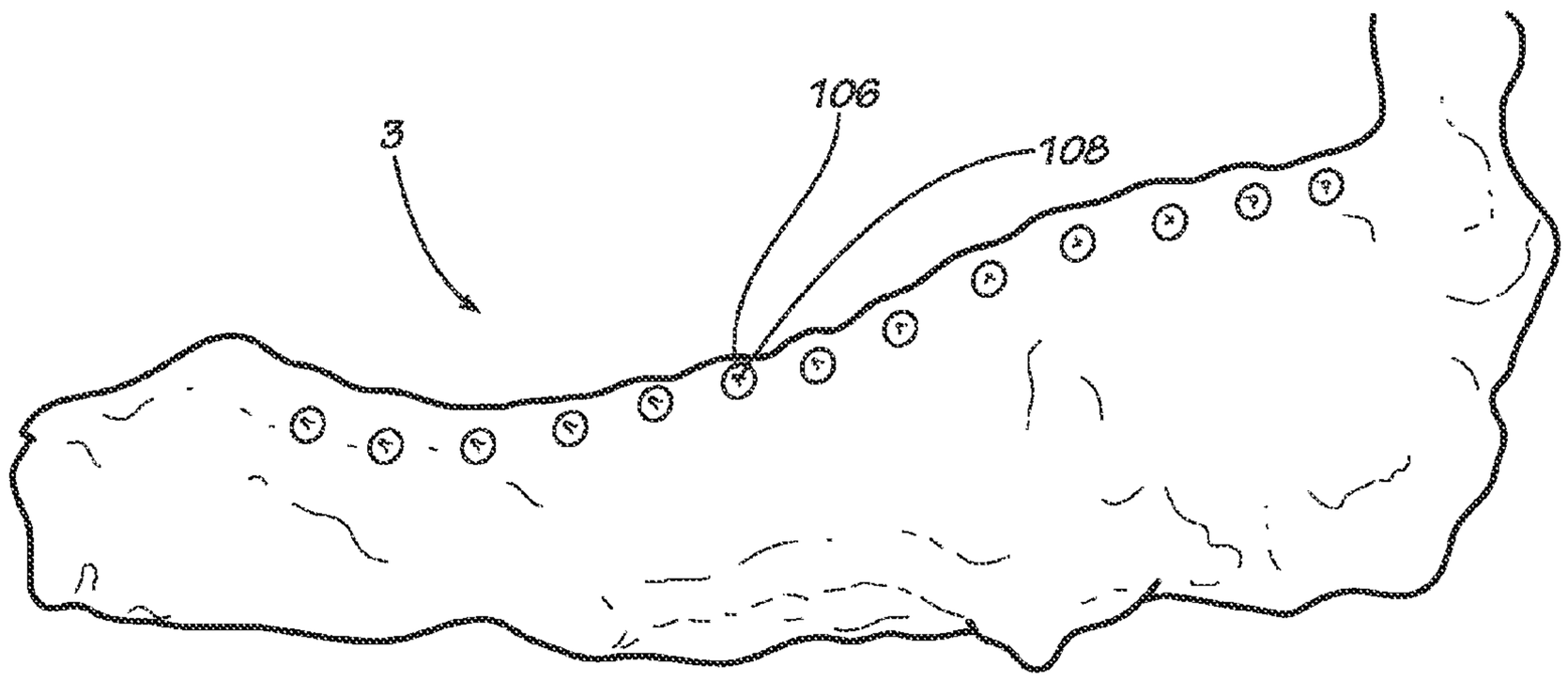


FIG. 4D

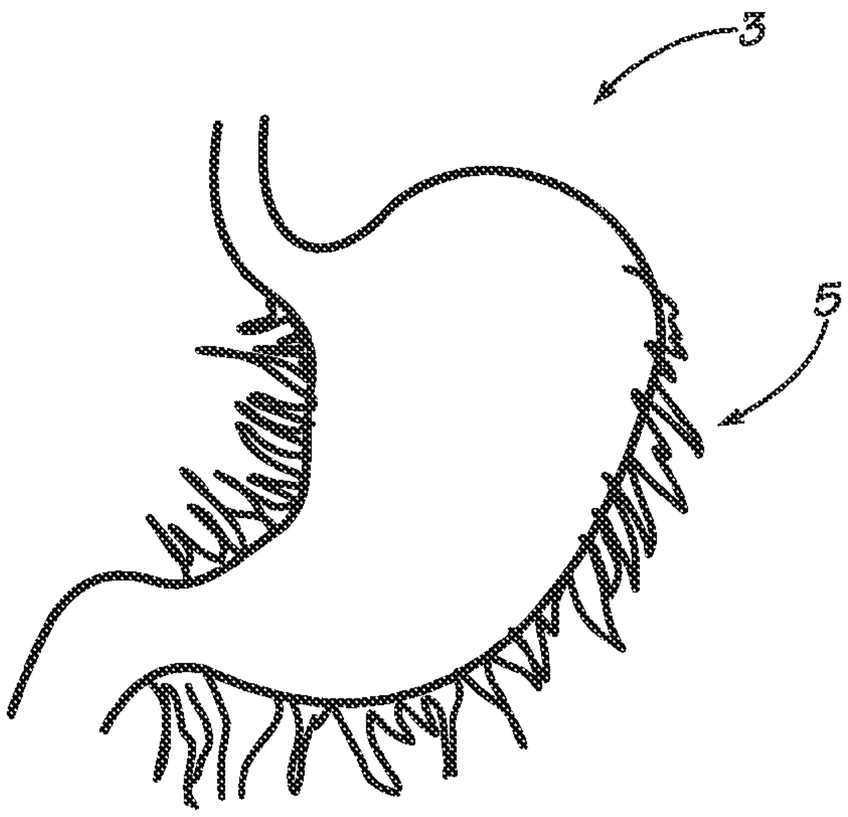


FIG. 5A

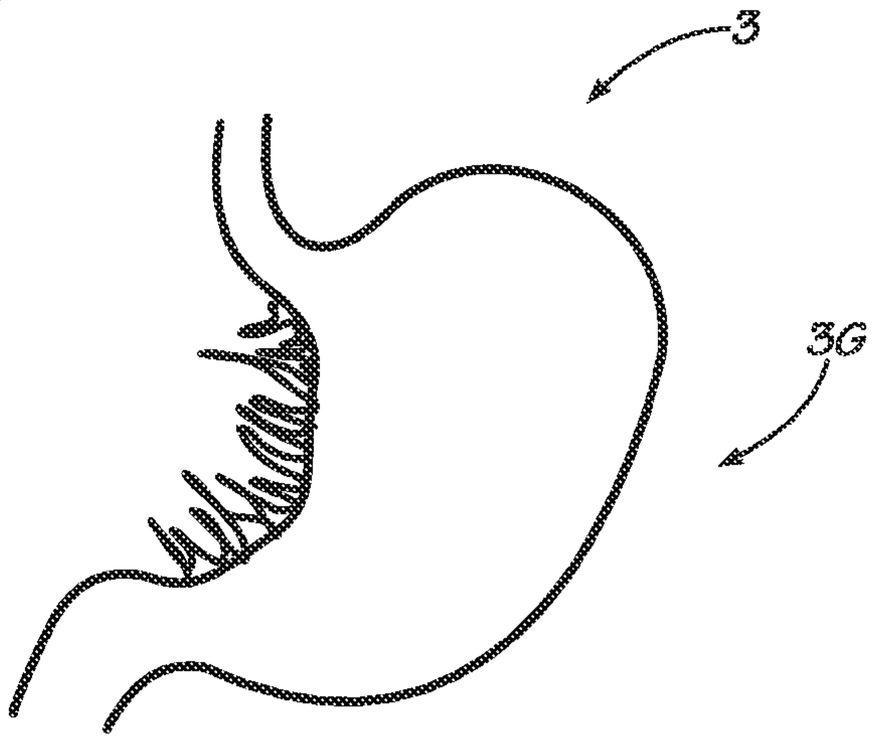


FIG. 5B

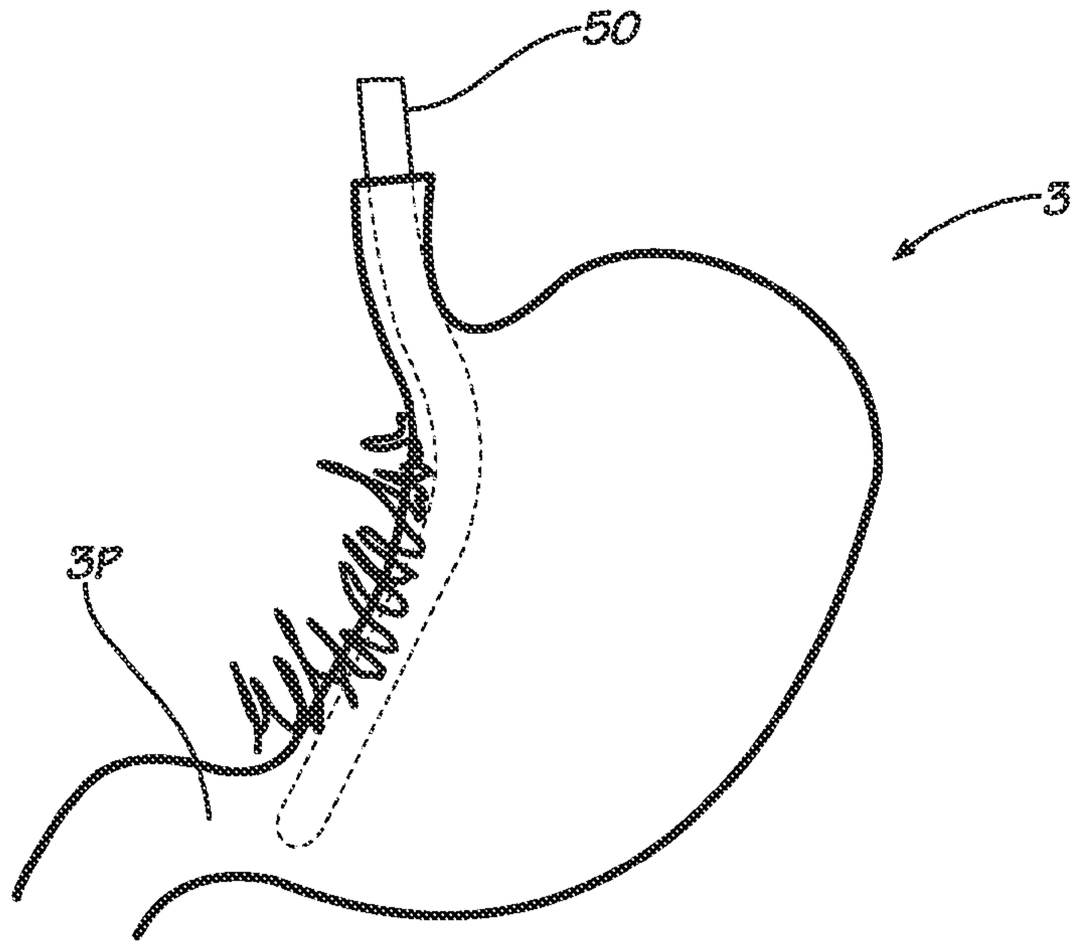


FIG. 5C

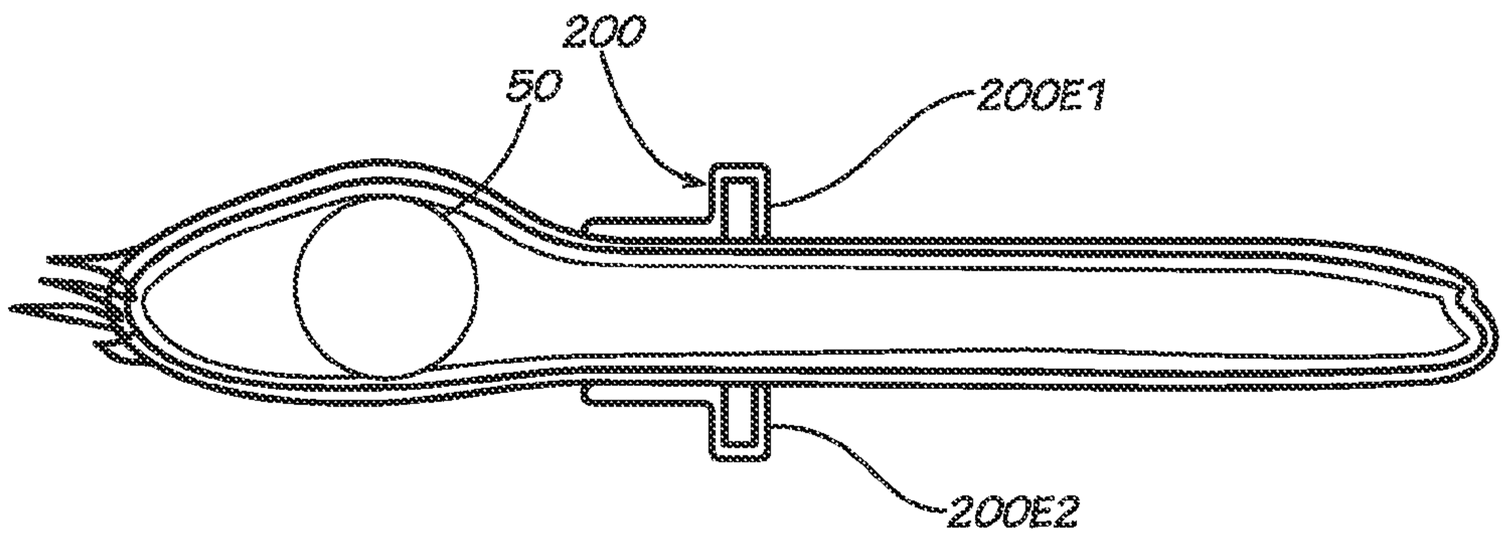


FIG. 5D

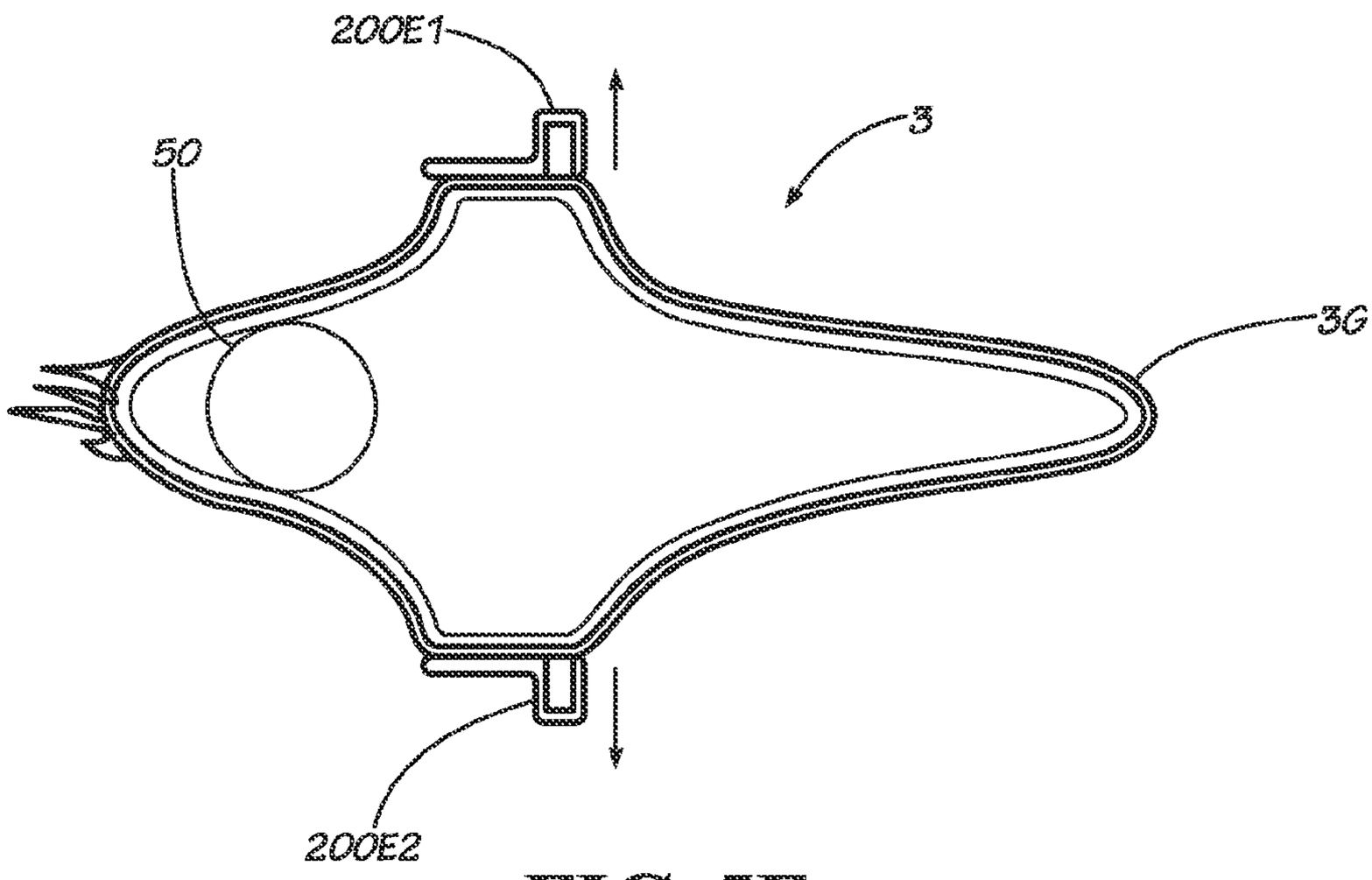


FIG. 5E

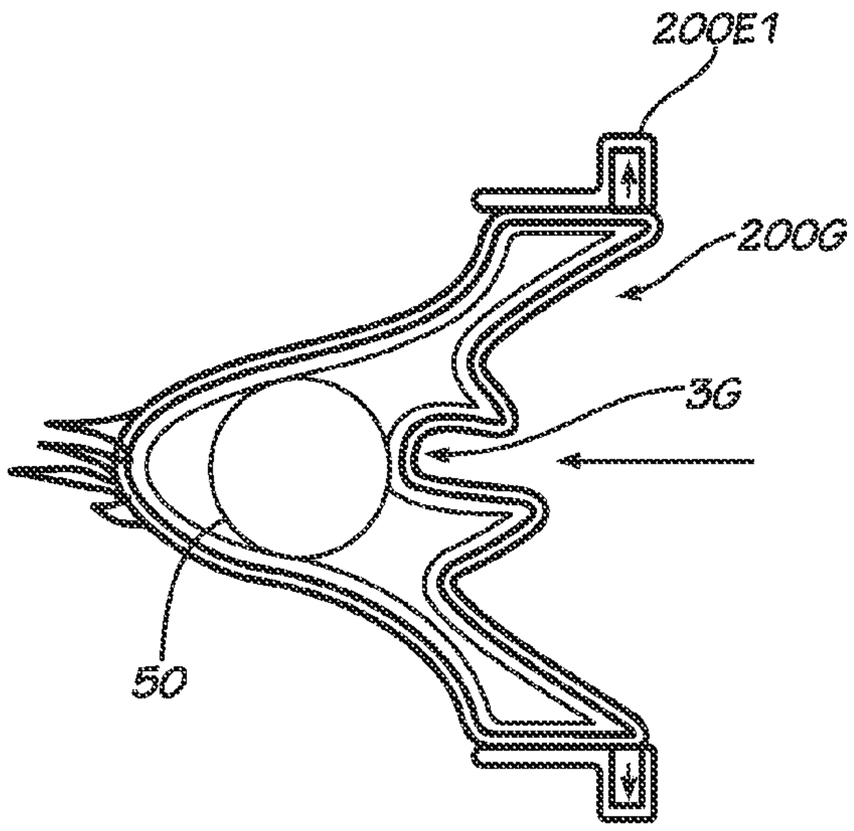


FIG. 5F

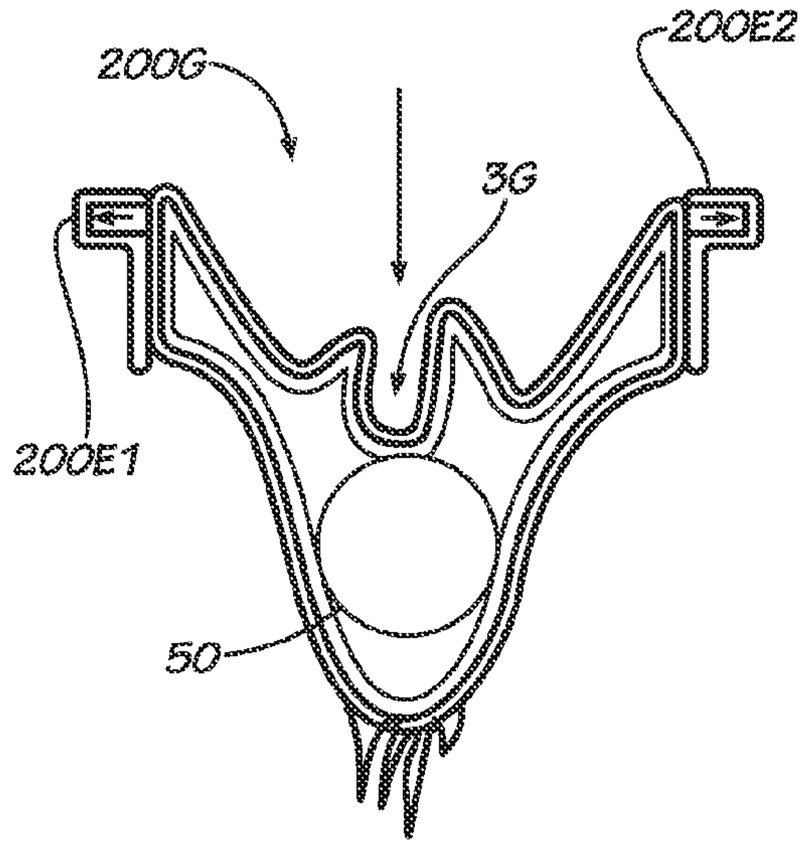


FIG. 5F'

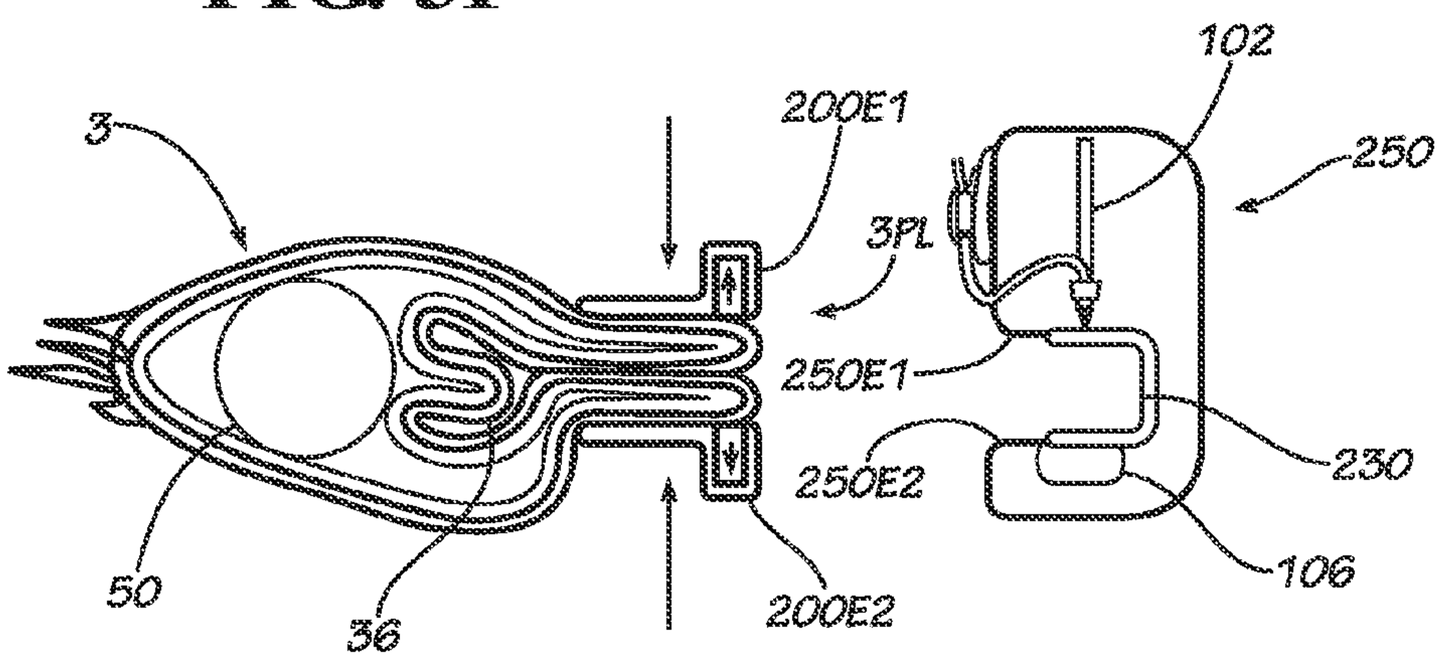


FIG. 5G

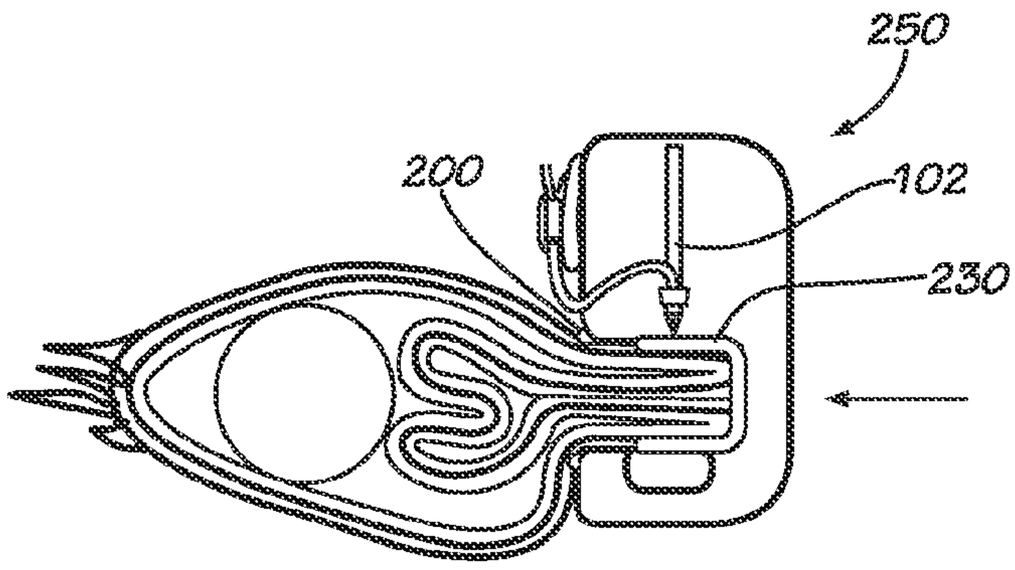


FIG. 5H

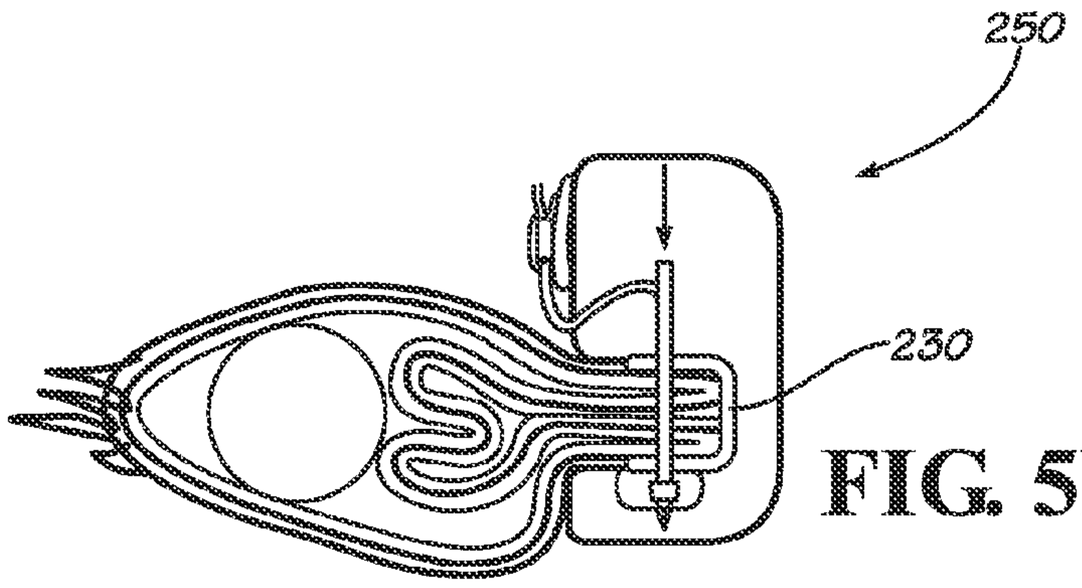


FIG. 5I

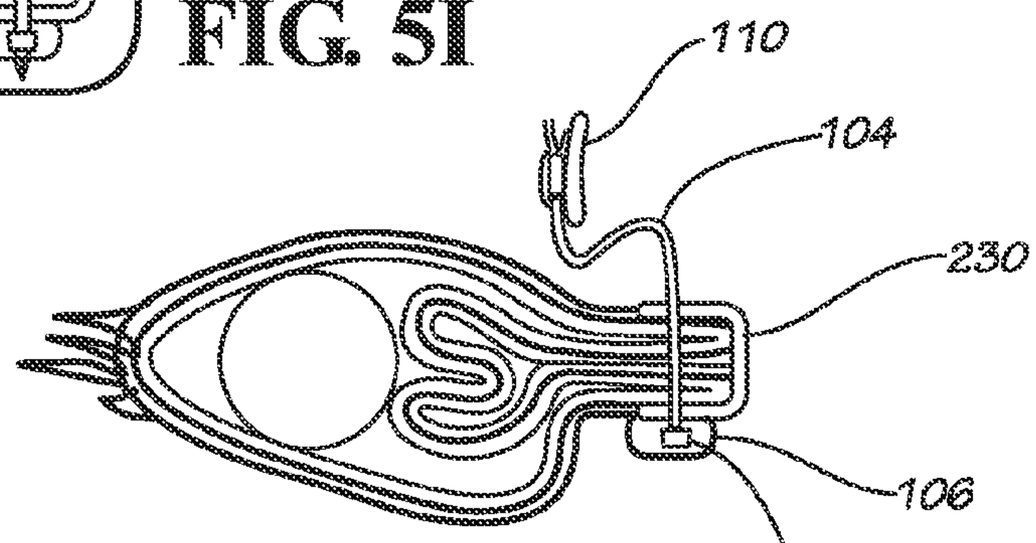


FIG. 5J

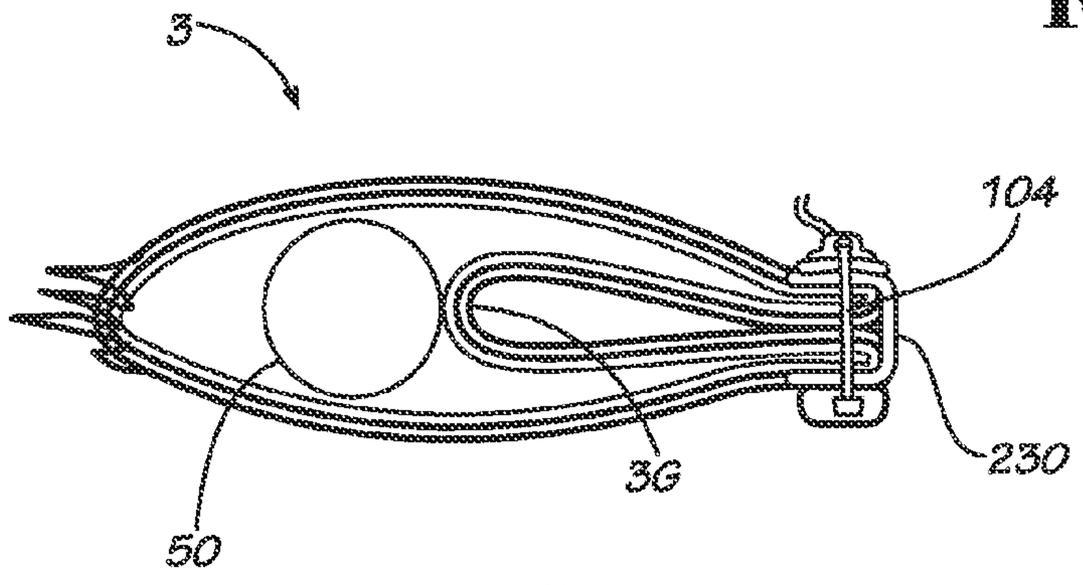


FIG. 5K

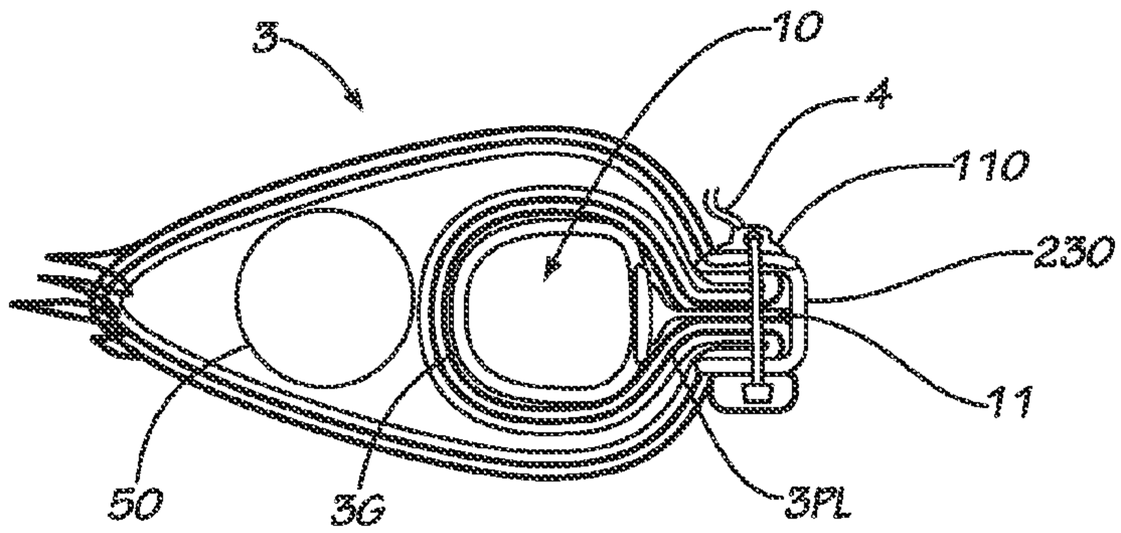


FIG. 5L

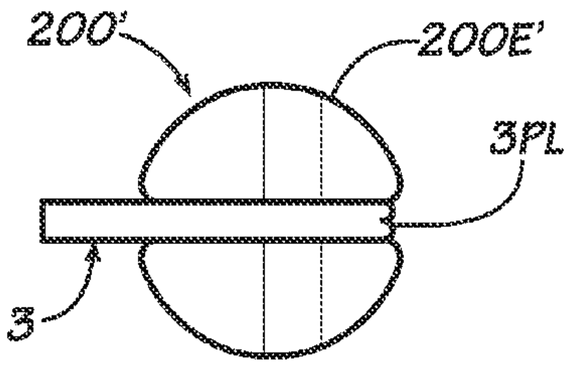


FIG. 5M

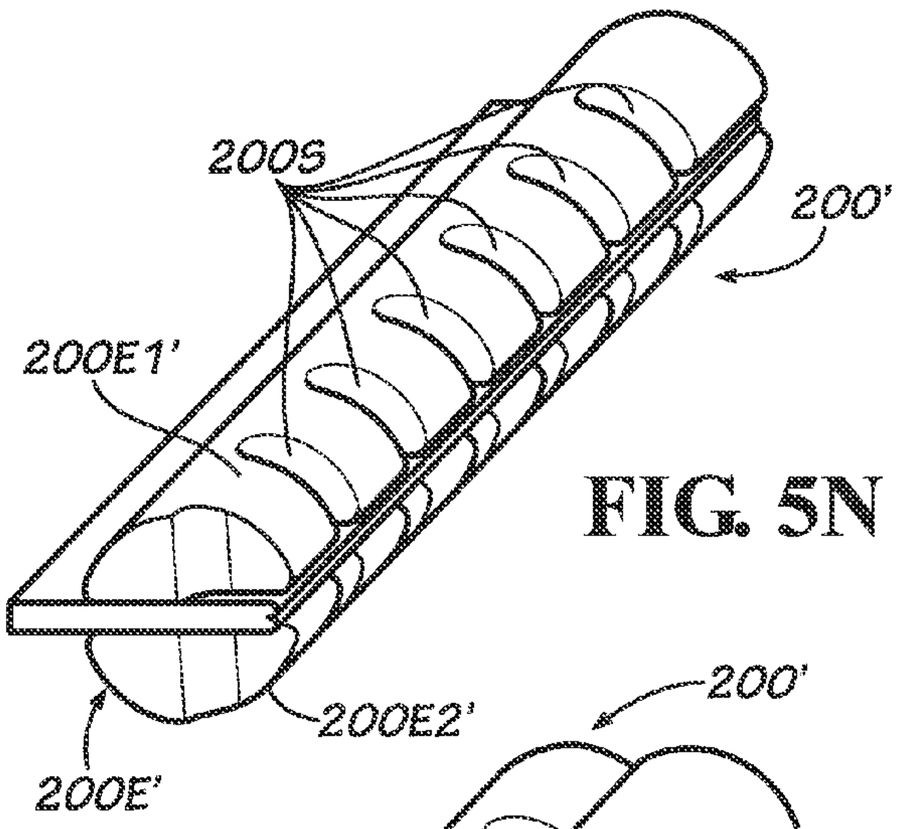


FIG. 5N

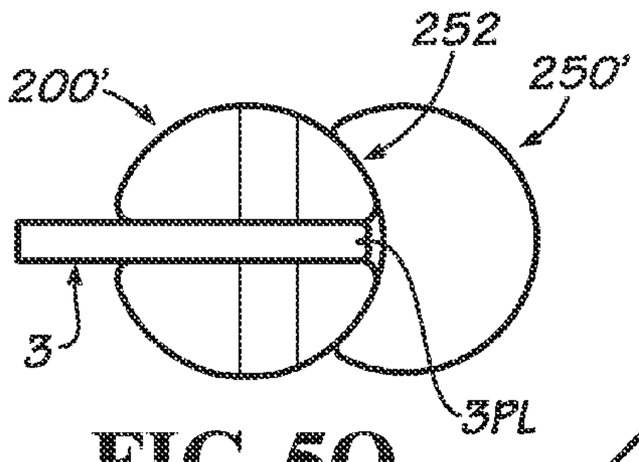


FIG. 5O

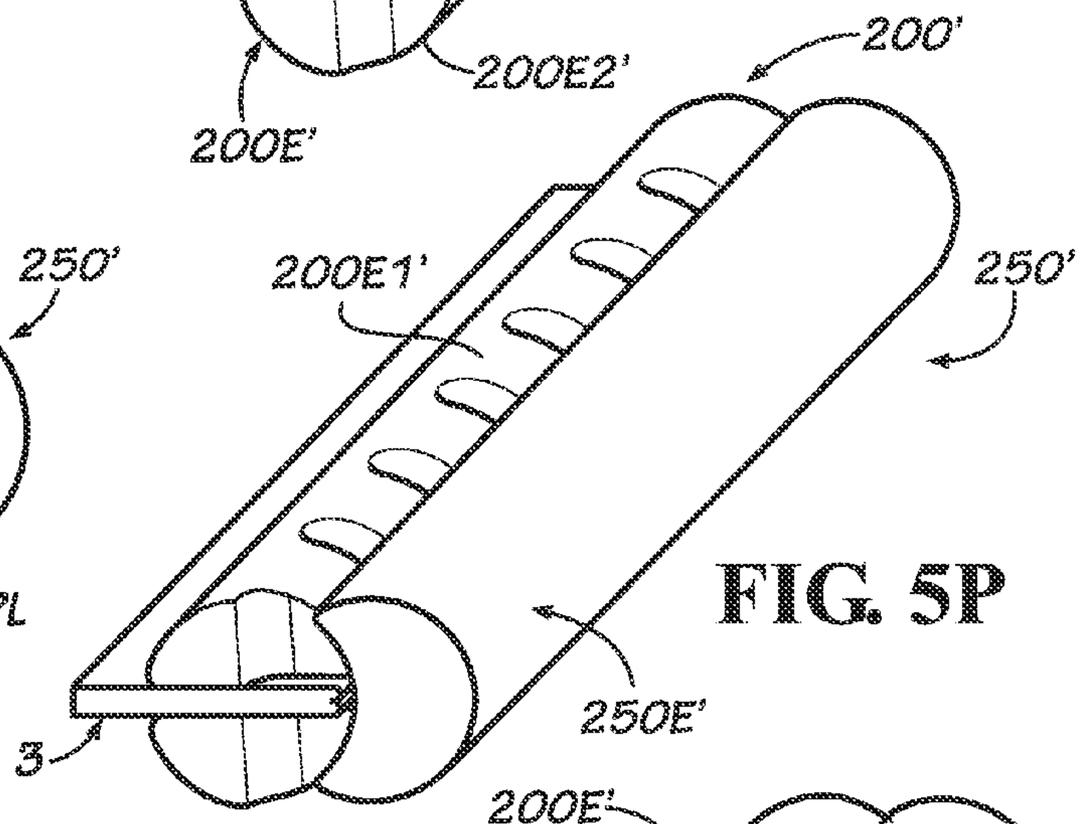


FIG. 5P

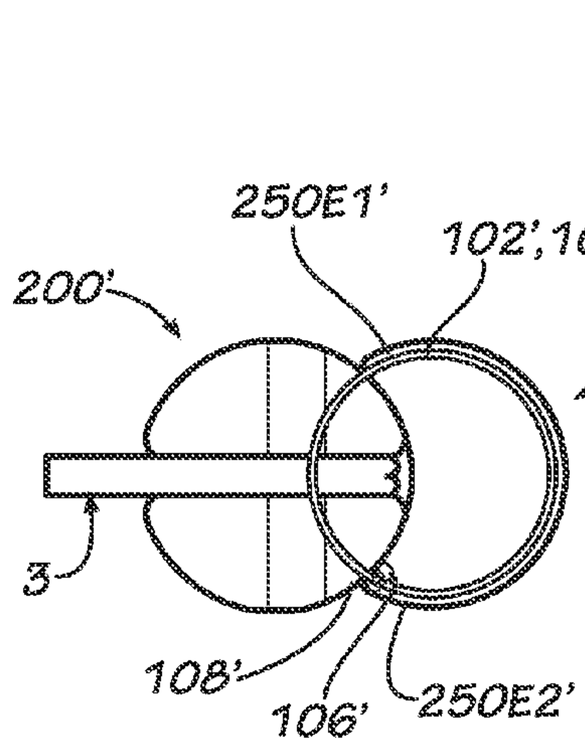


FIG. 5Q

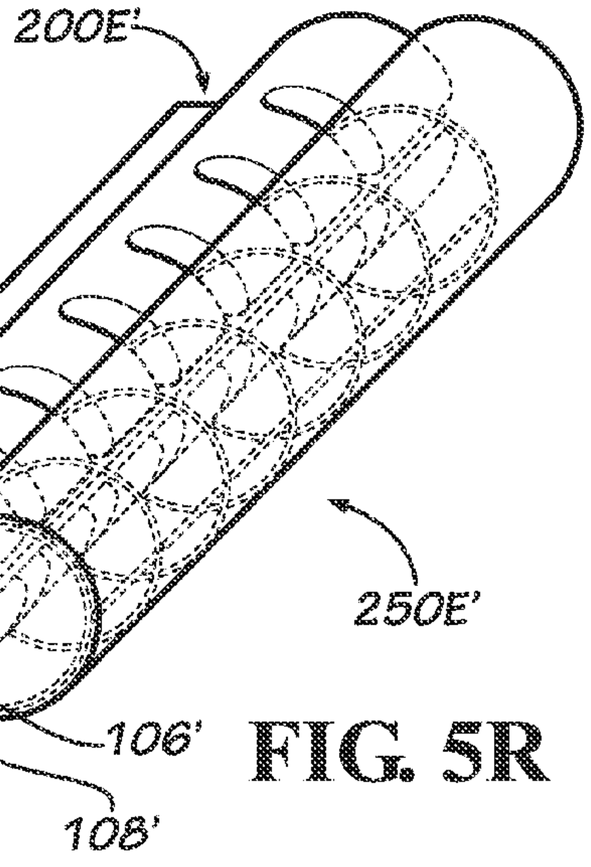


FIG. 5R

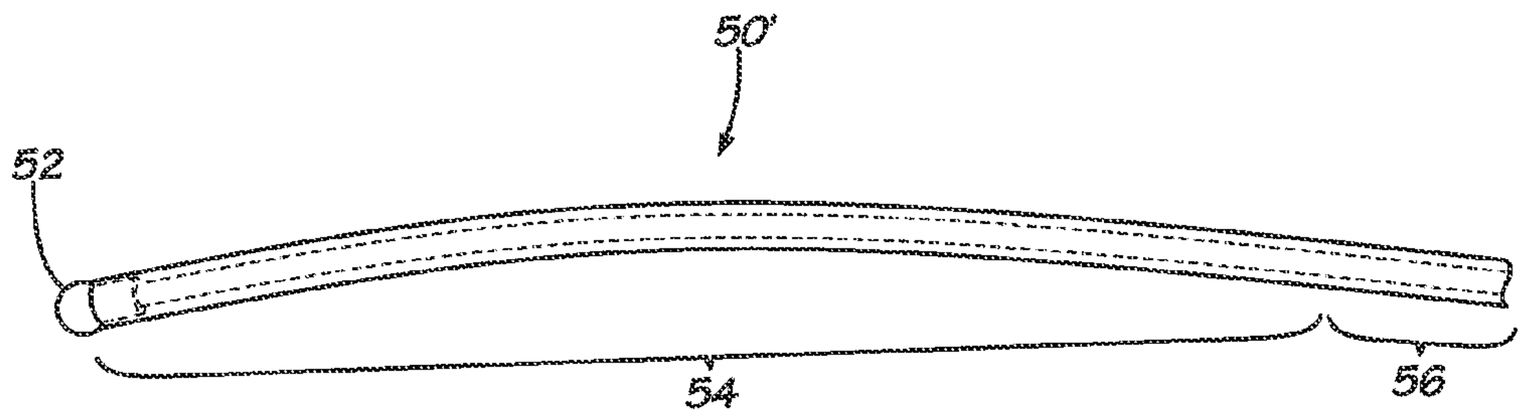


FIG. 6

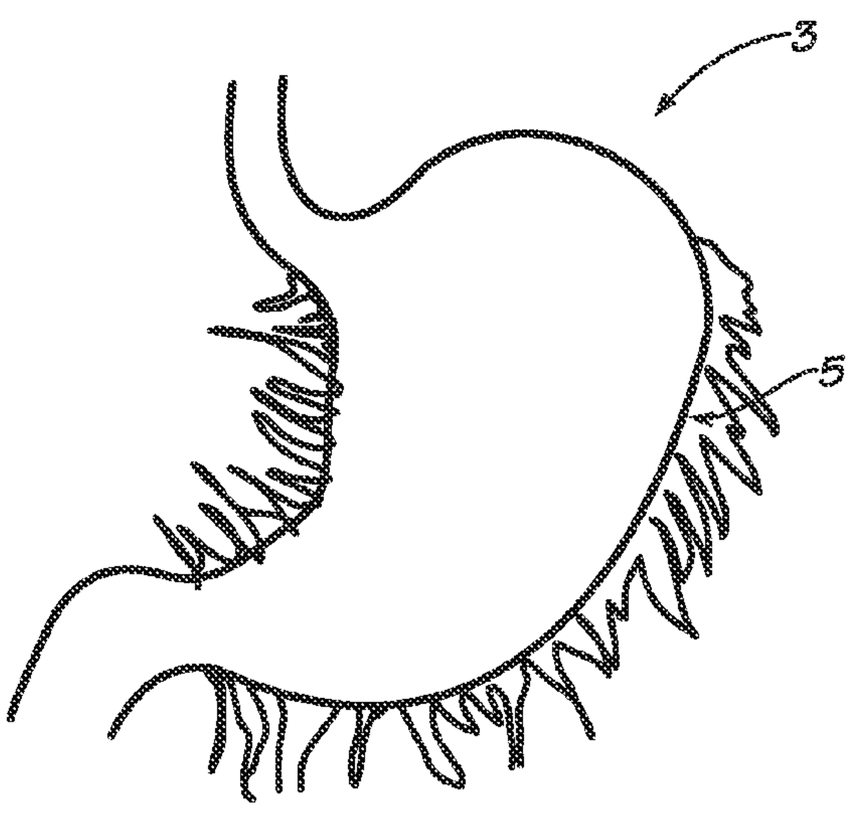


FIG. 7A

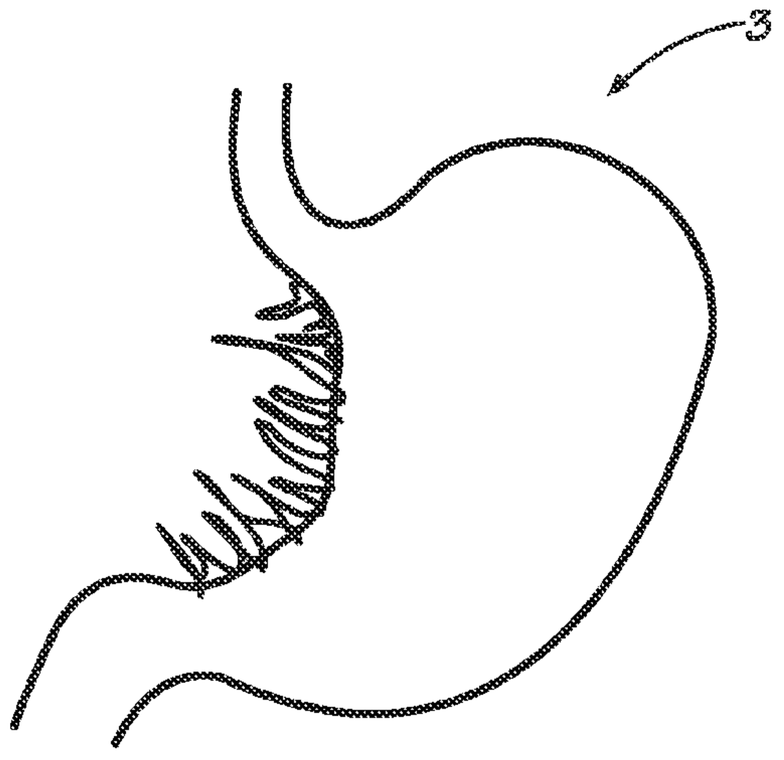


FIG. 7B

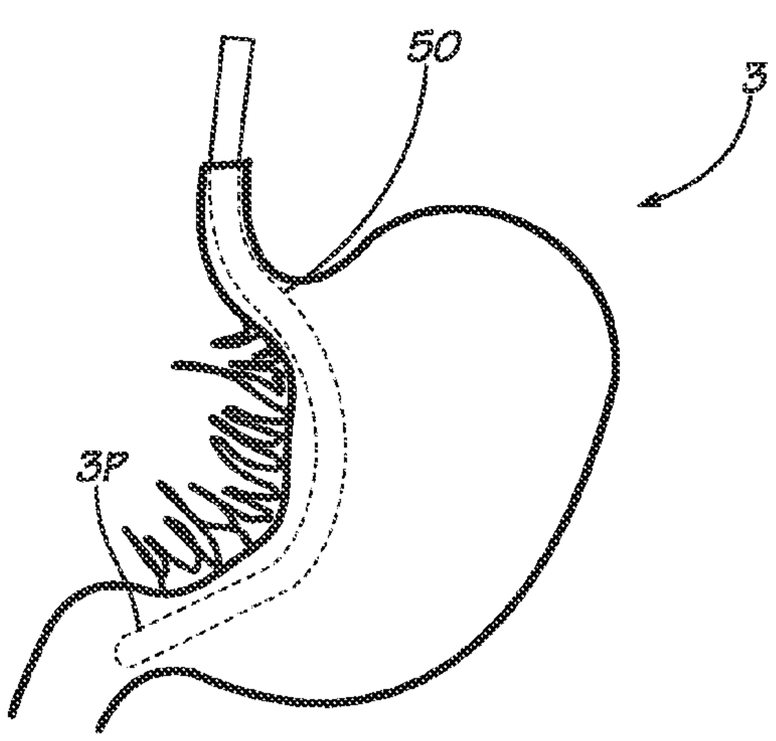


FIG. 7C

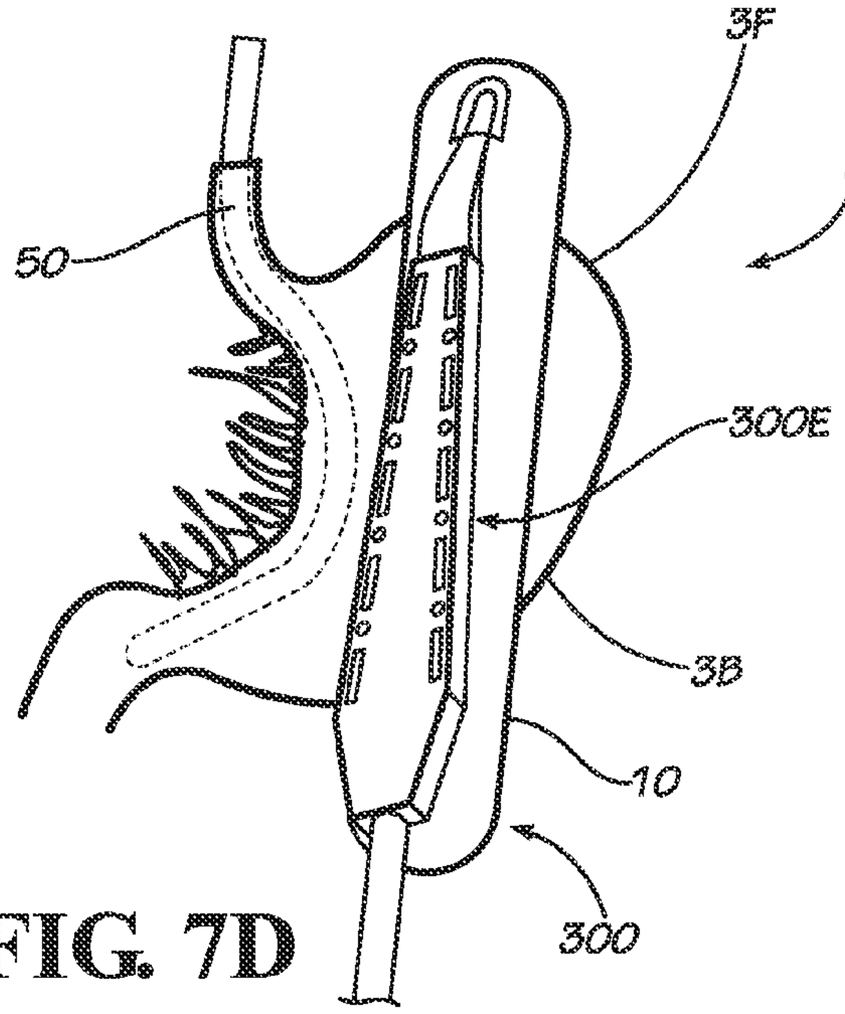


FIG. 7D

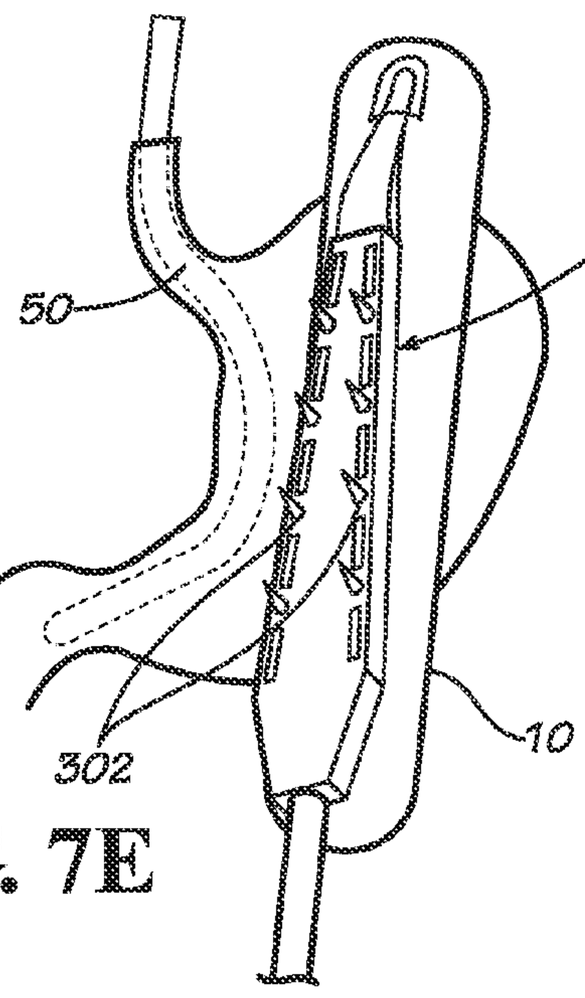


FIG. 7E

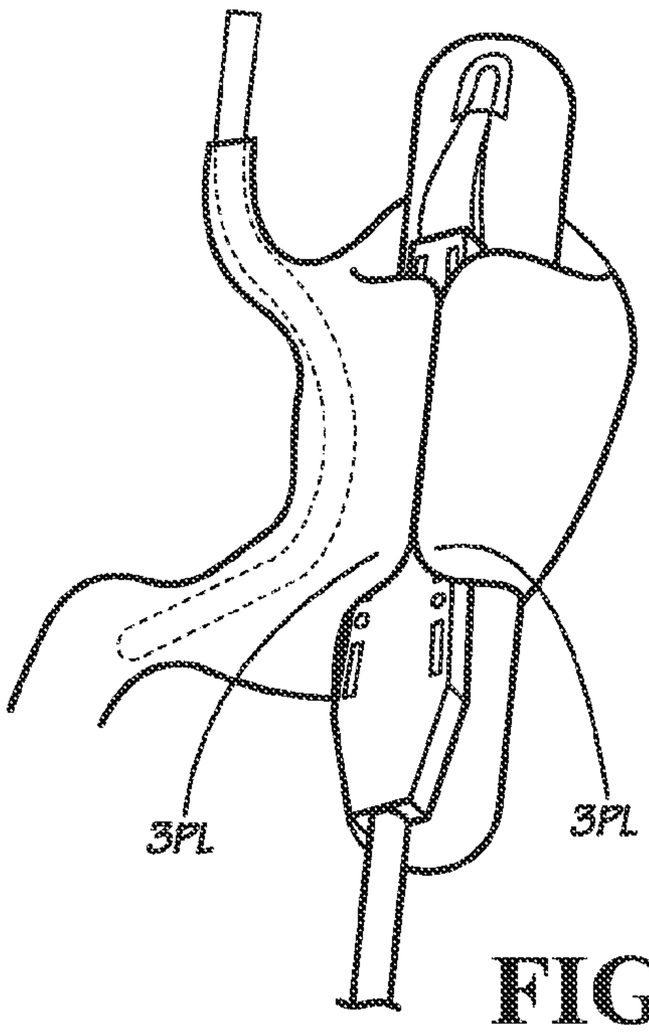


FIG. 7F

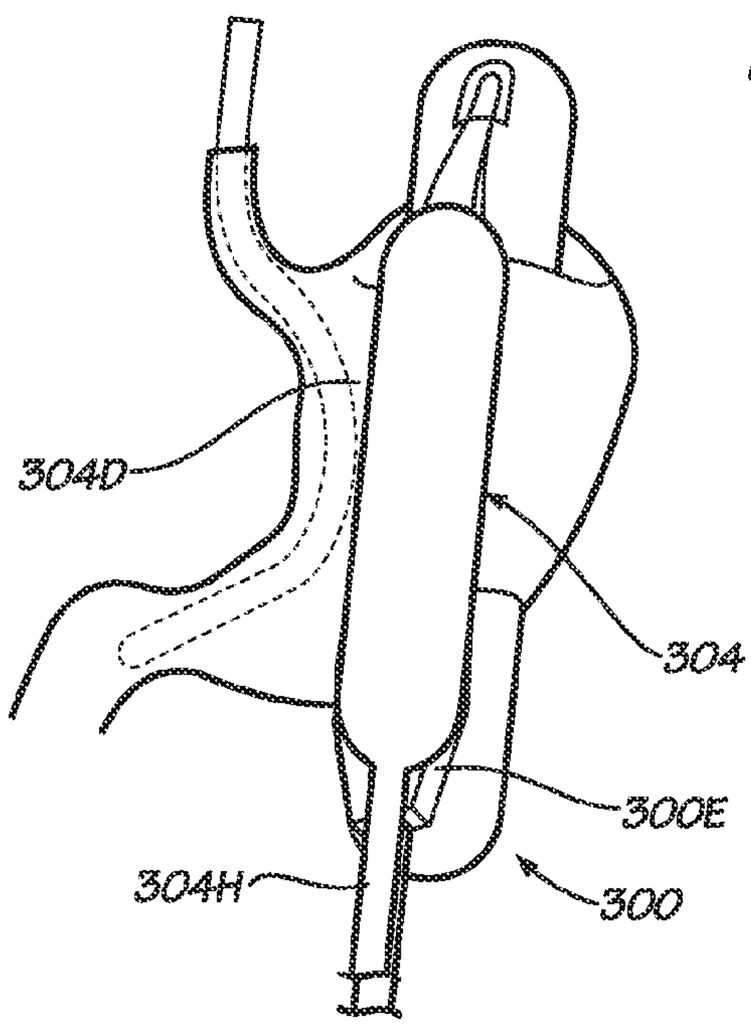


FIG. 7G

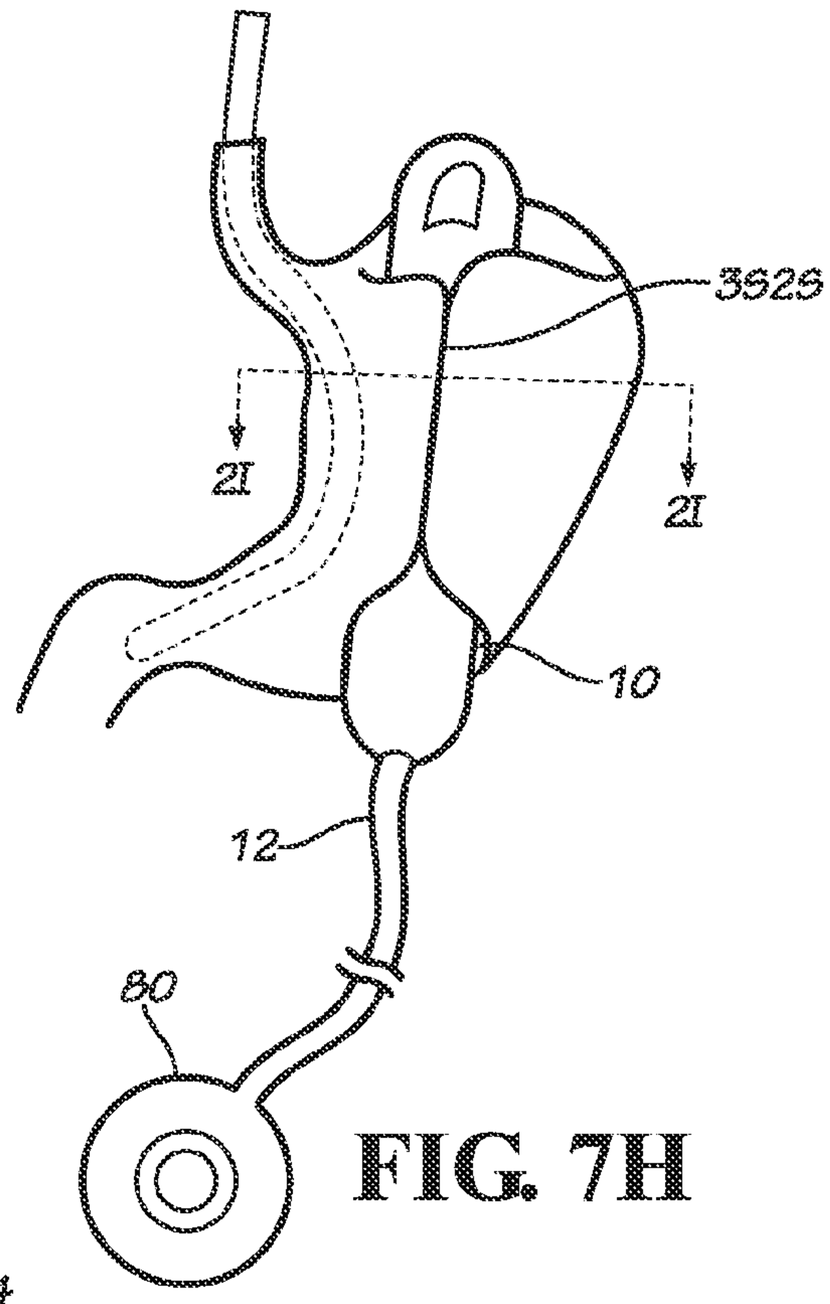
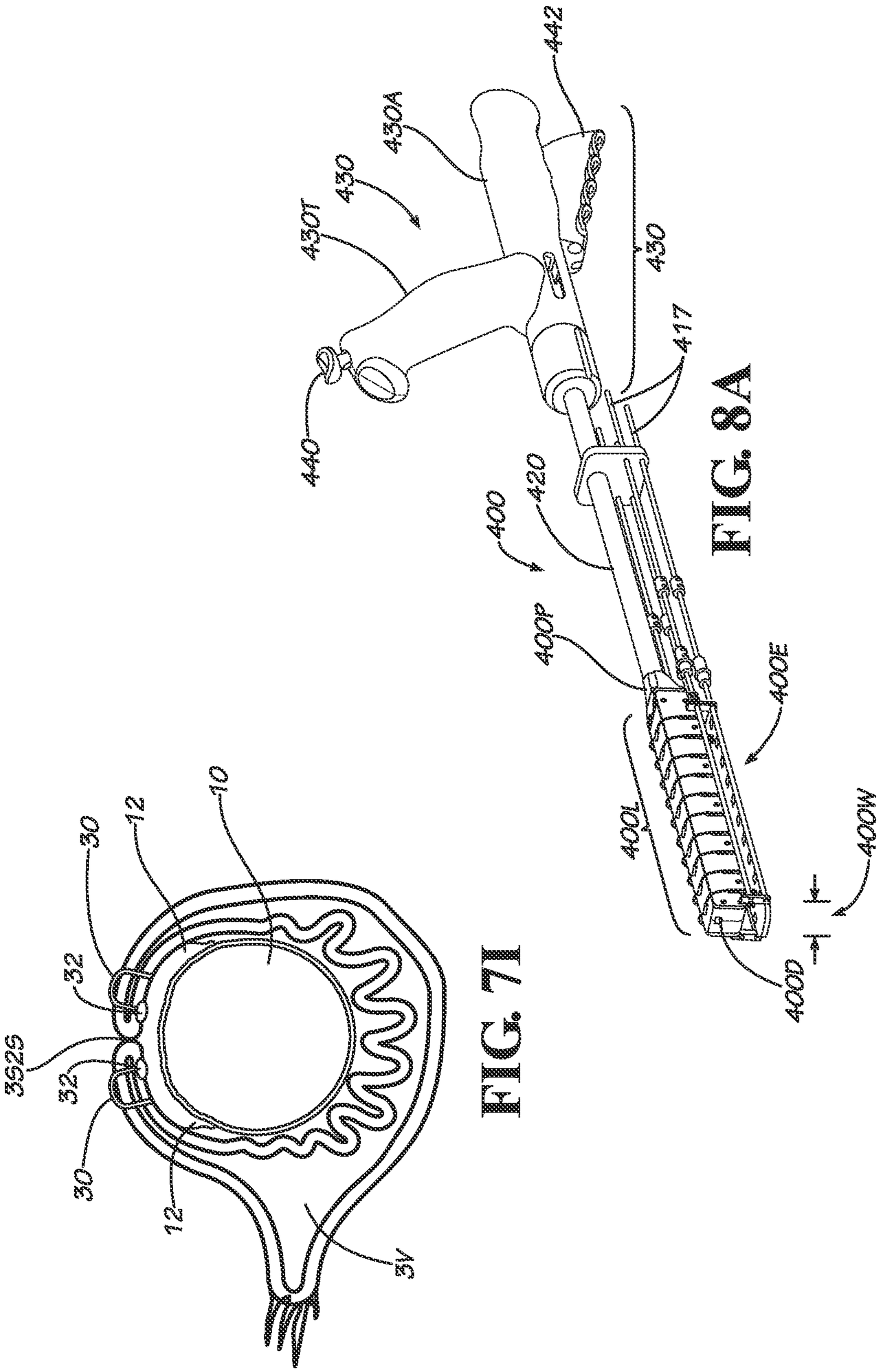


FIG. 7H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400E
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400D
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12
3V

FIG. 8A

FIG. 7I

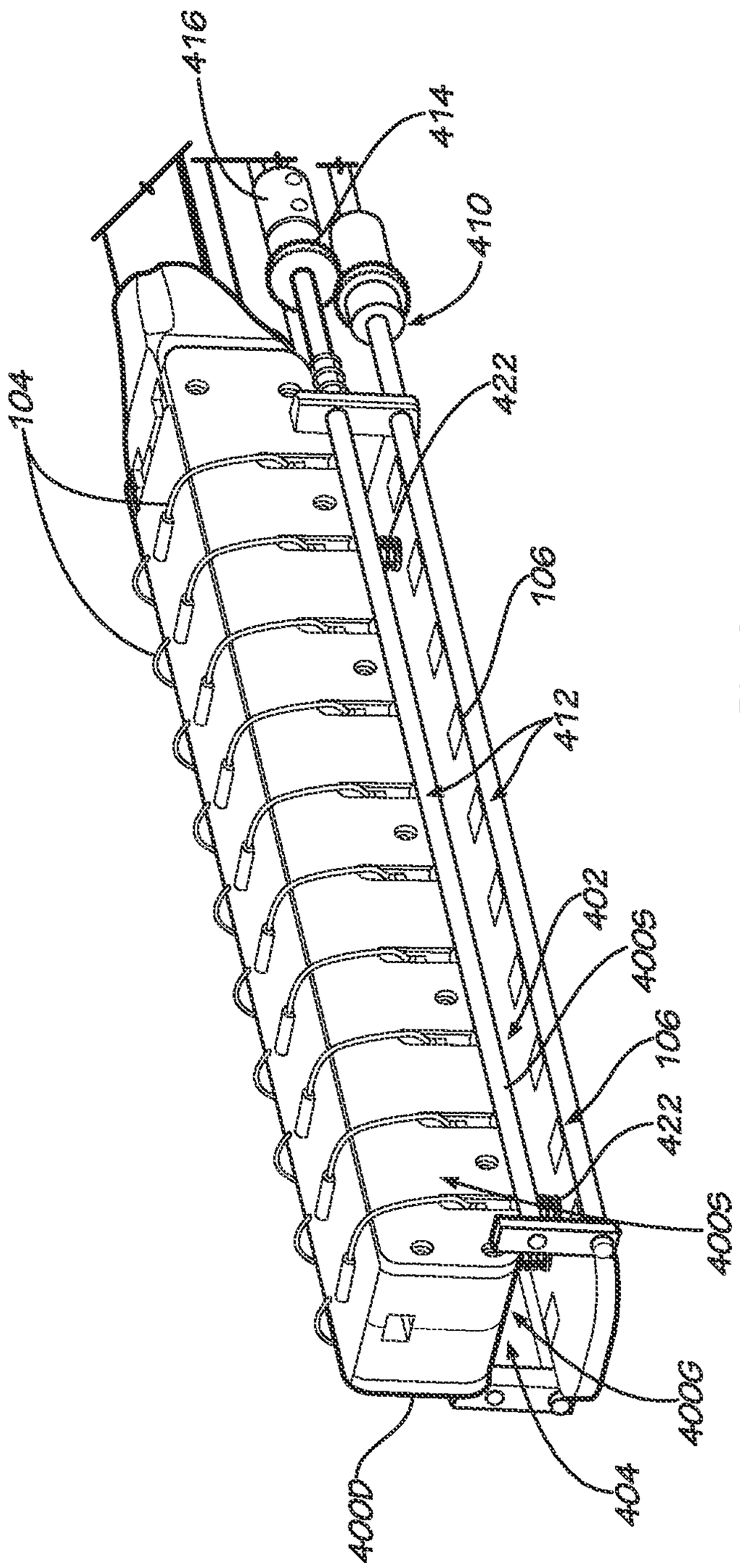

FIG. 8B

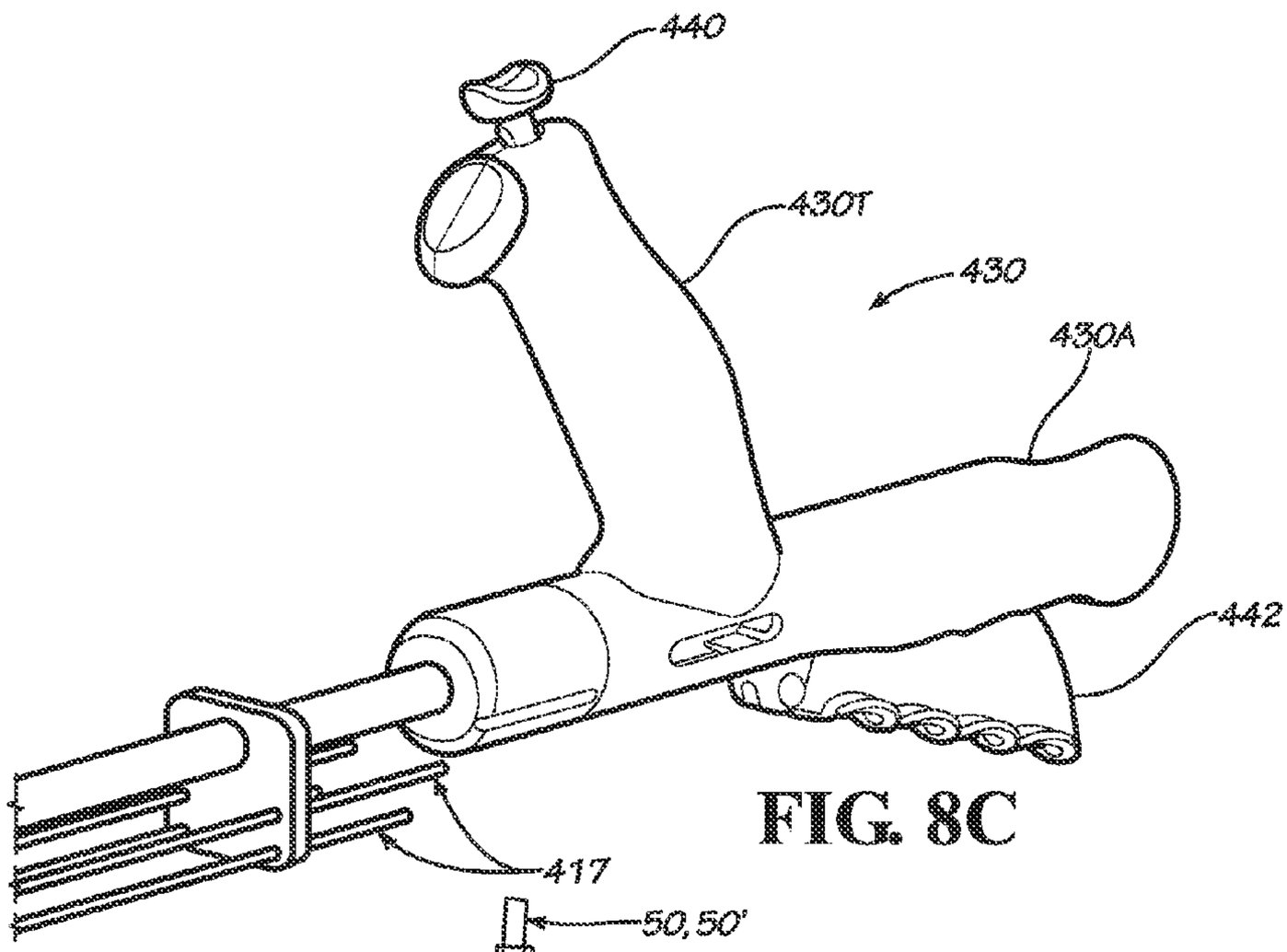

FIG. 8C

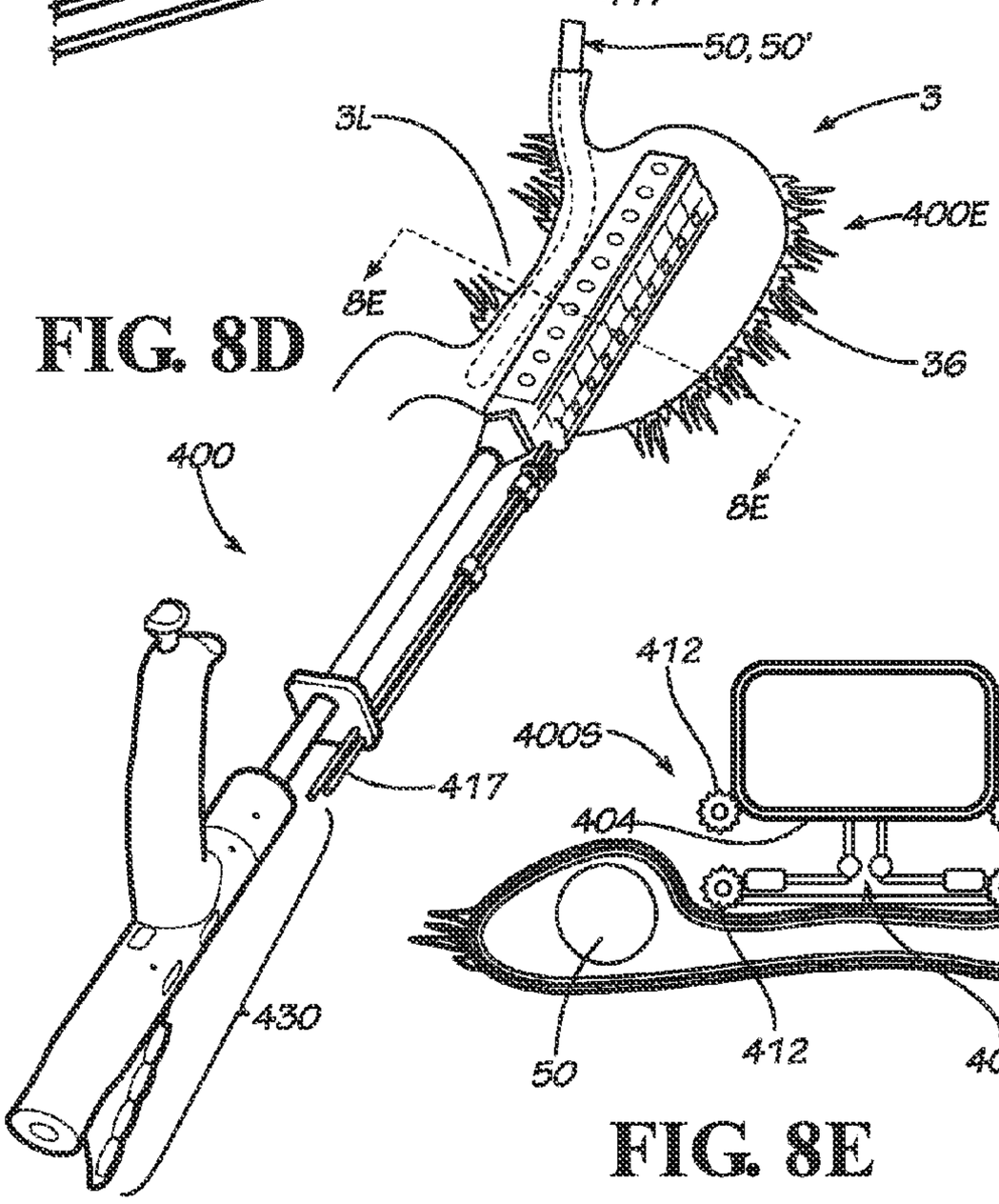

FIG. 8D

FIG. 8E

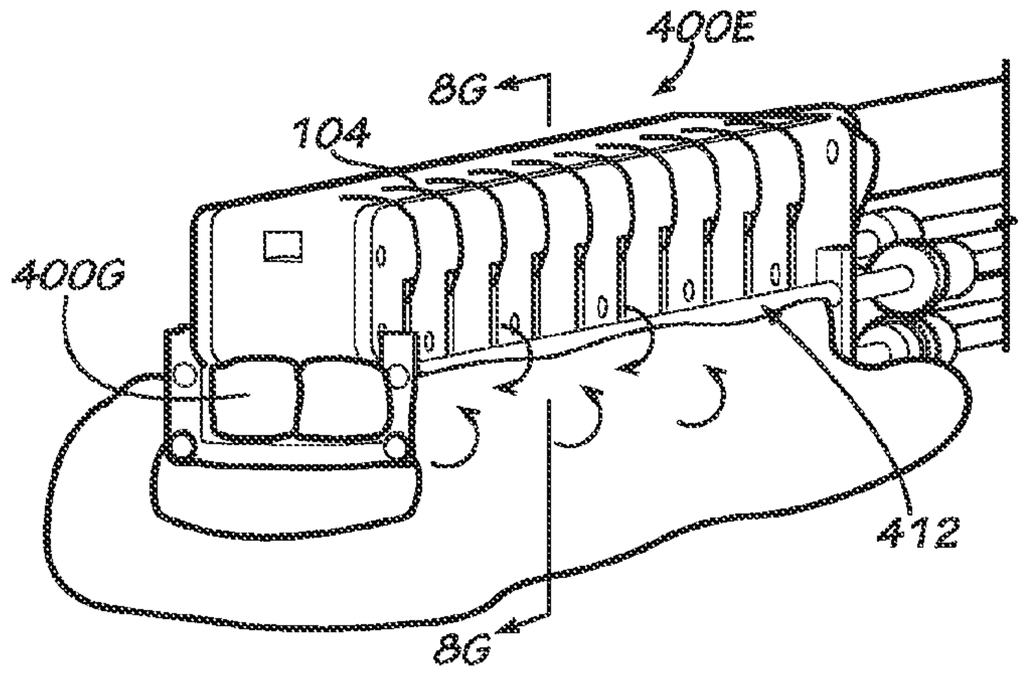

FIG. 8F

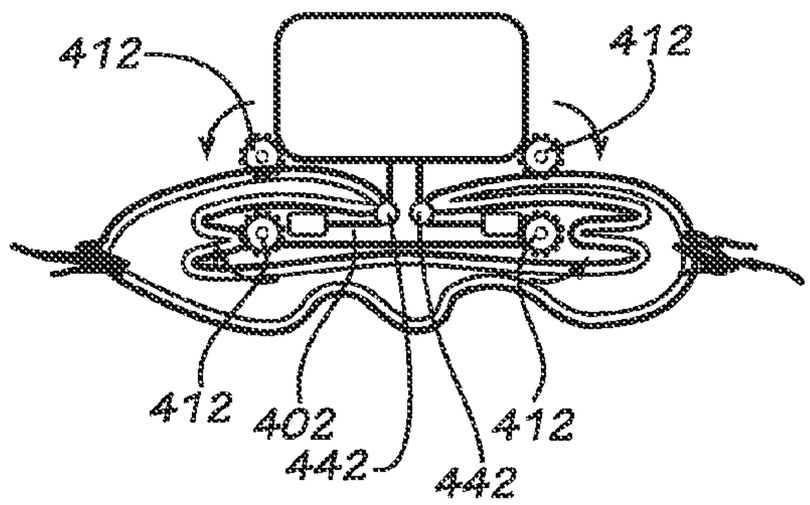

FIG. 8G

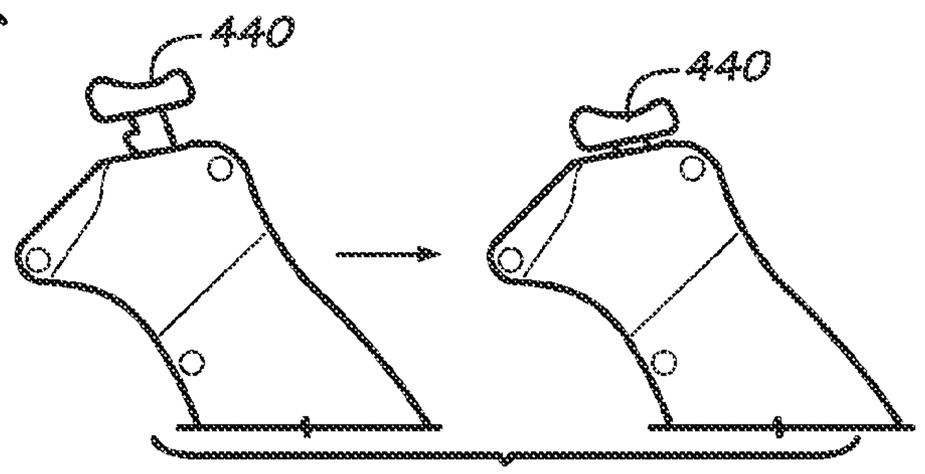

FIG. 8H

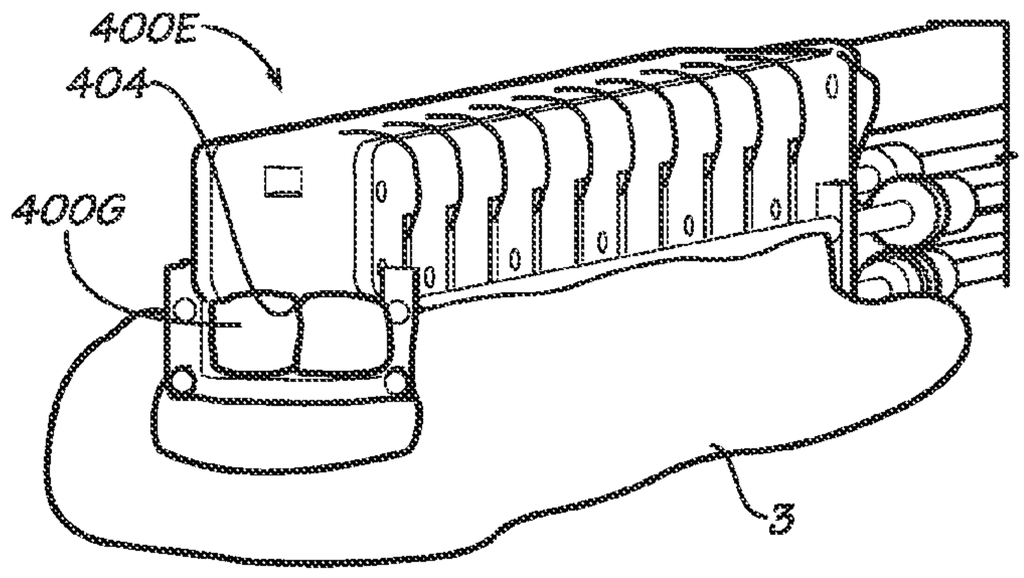

FIG. 8I

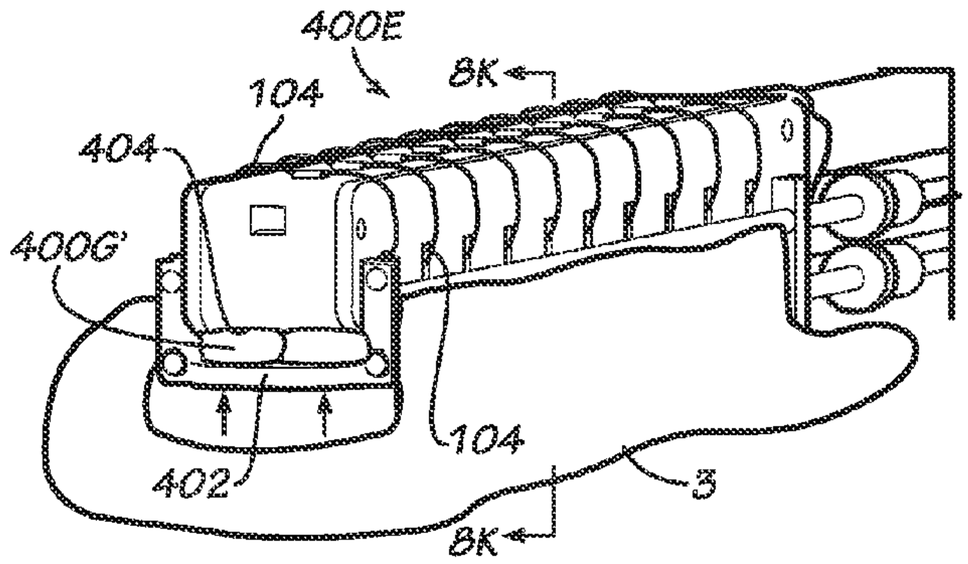

FIG. 8J

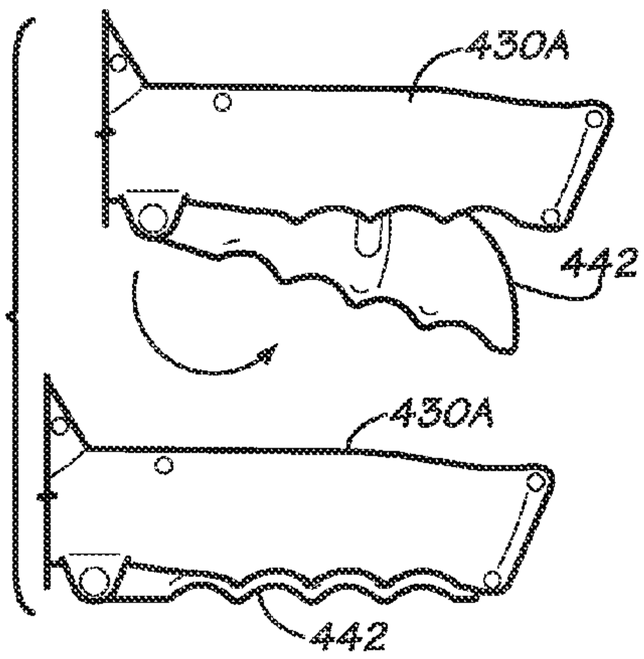

FIG. 8L

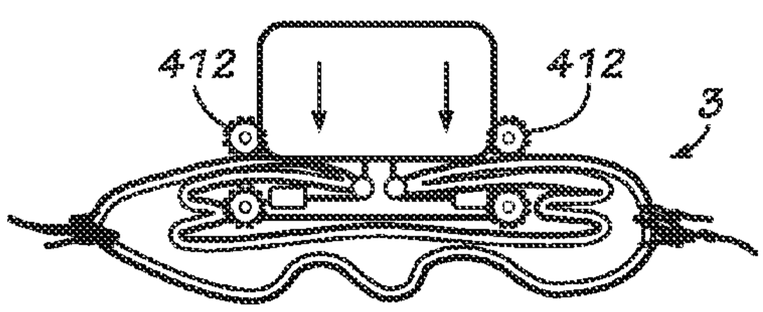

FIG. 8K

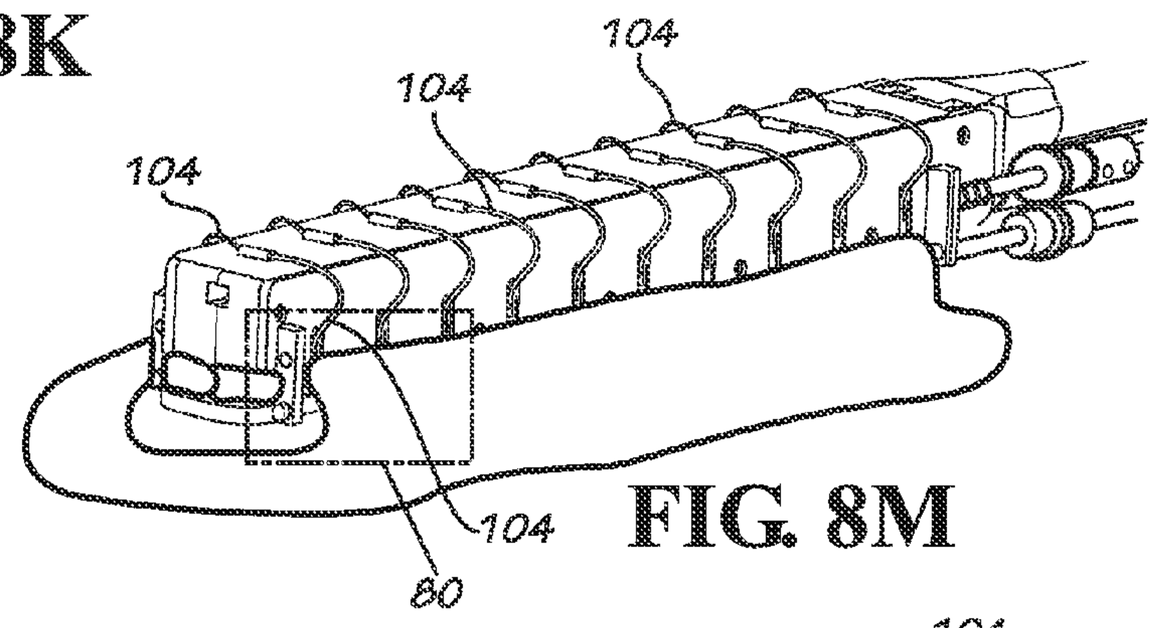

FIG. 8M

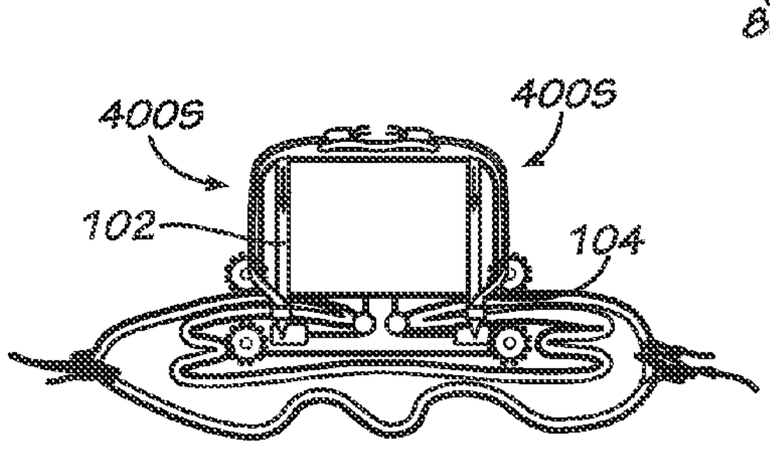

FIG. 8N

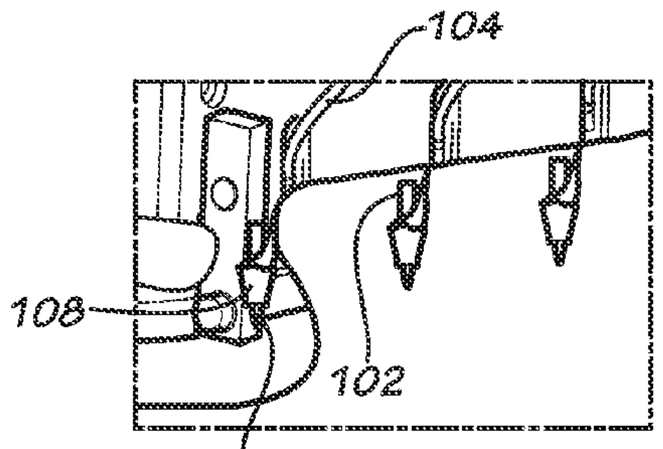

FIG. 8O

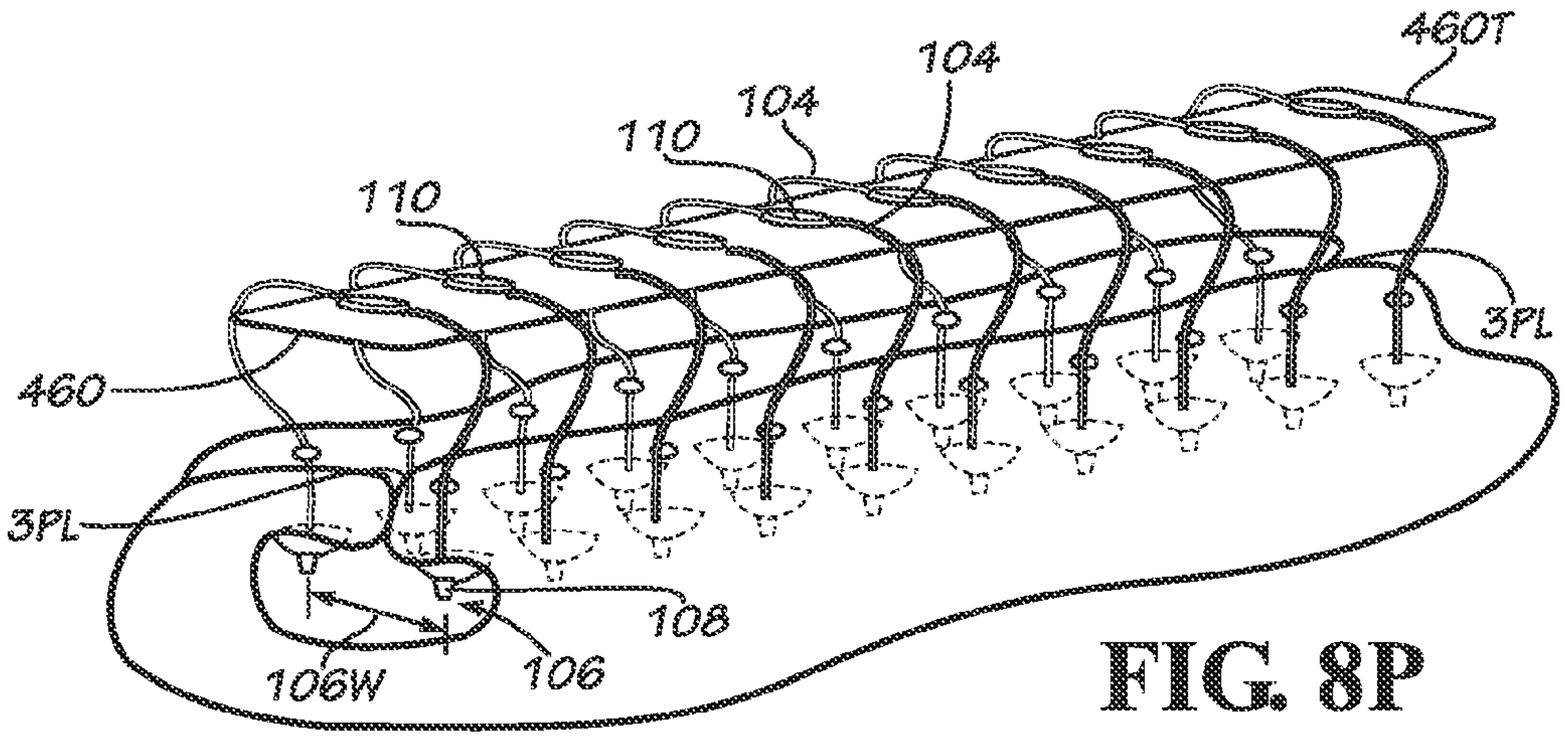

FIG. 8P

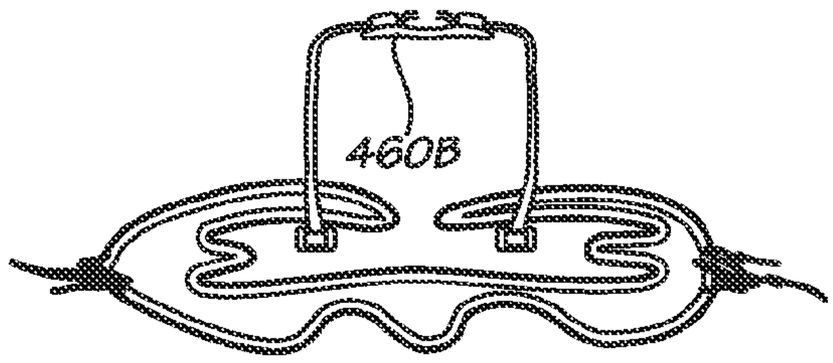

FIG. 8Q

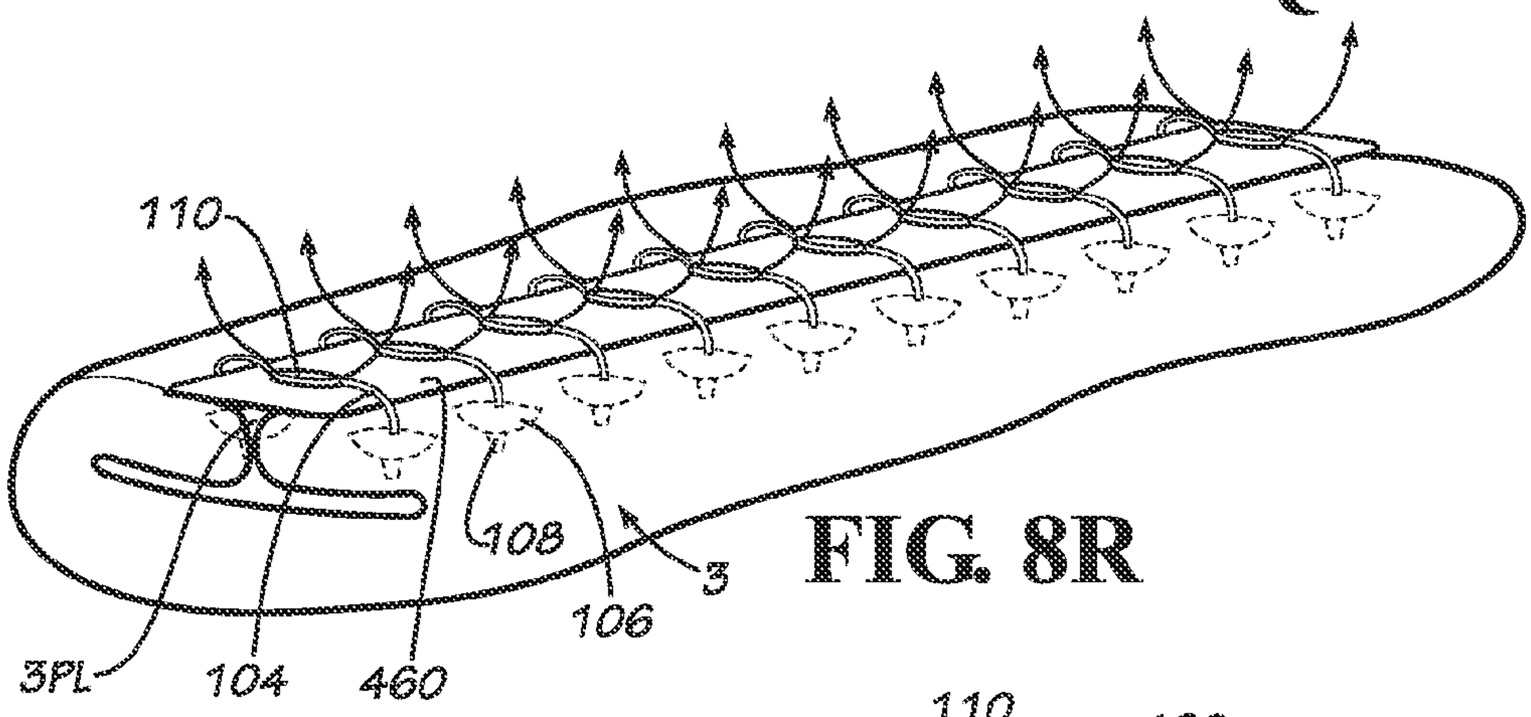

FIG. 8R

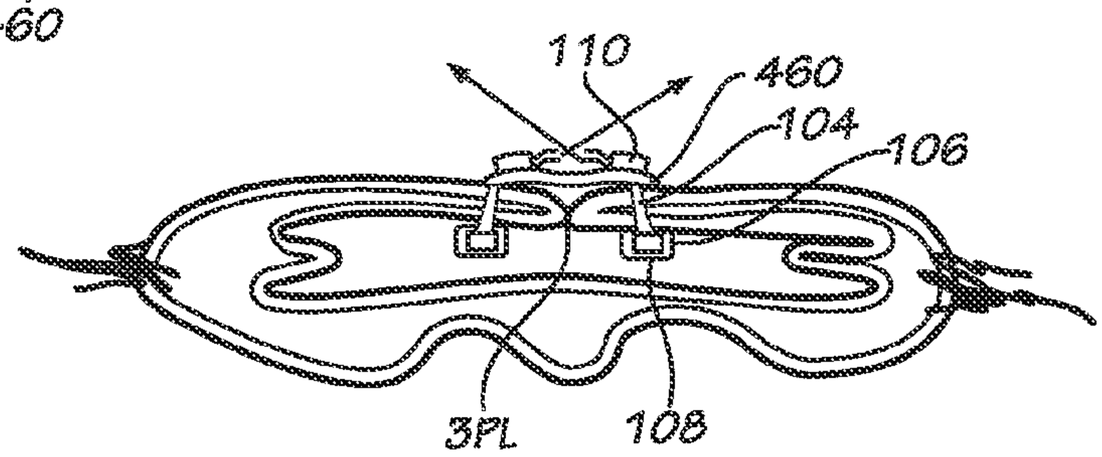

FIG. 8S

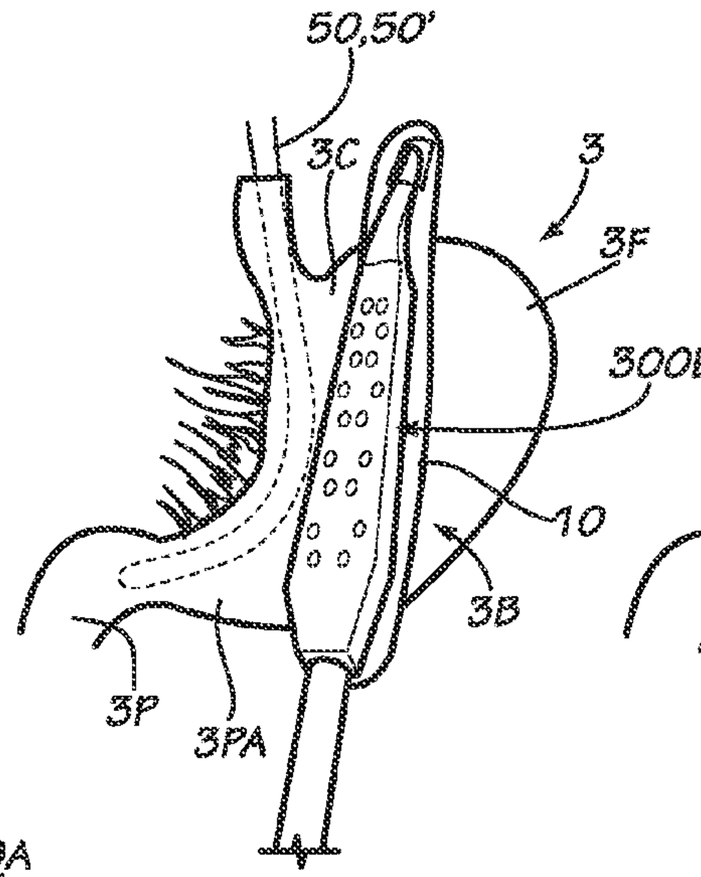

FIG. 10A

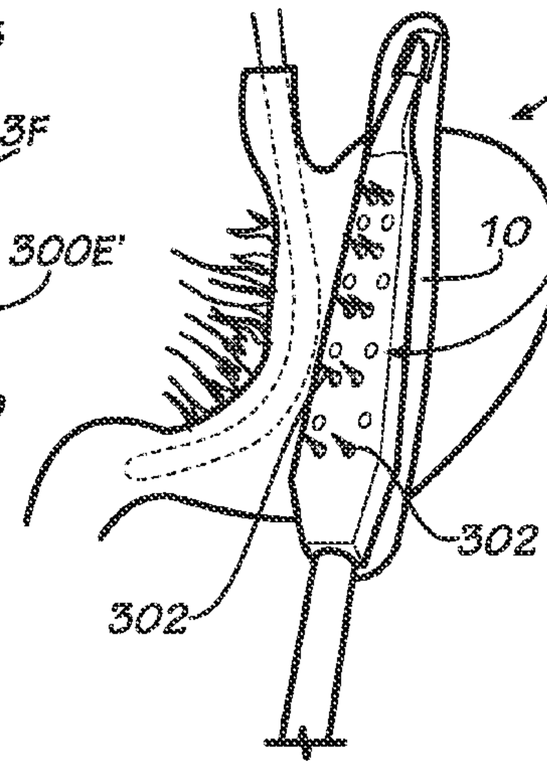

FIG. 10B

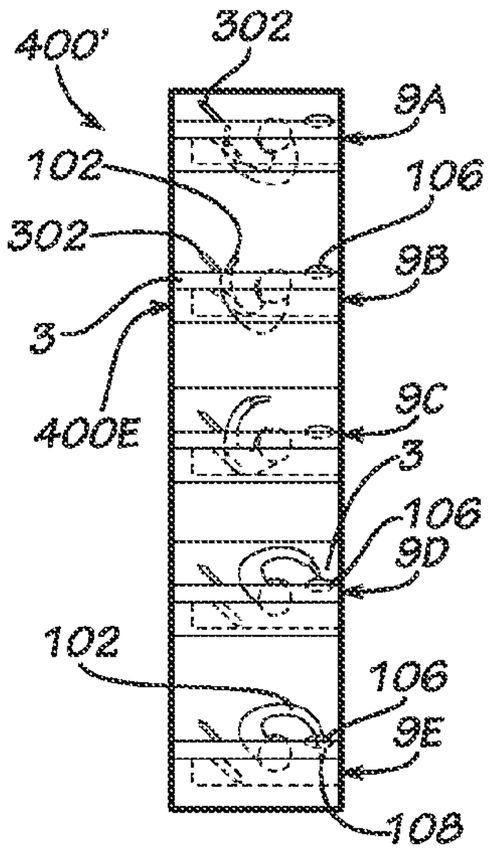

FIG. 9

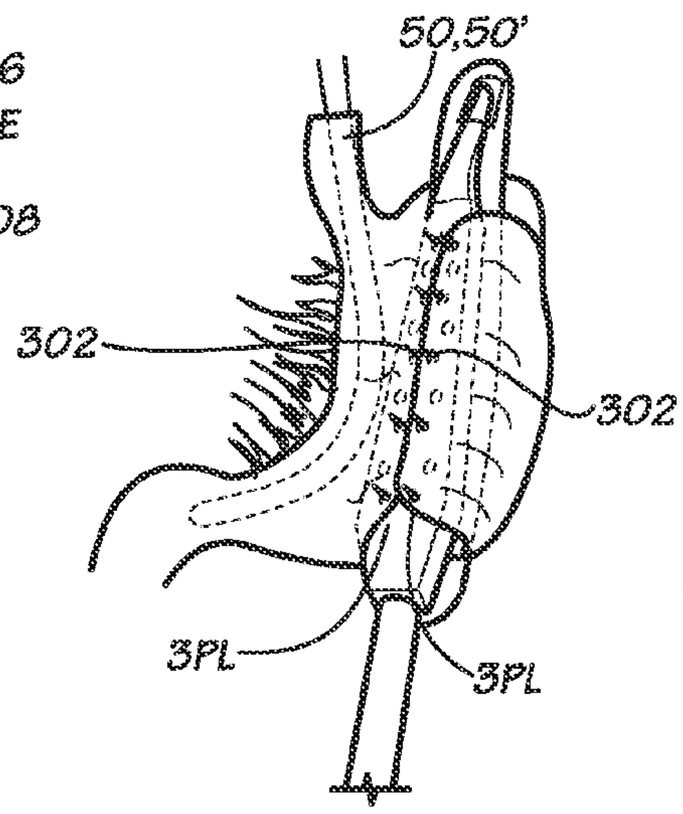

FIG. 10C

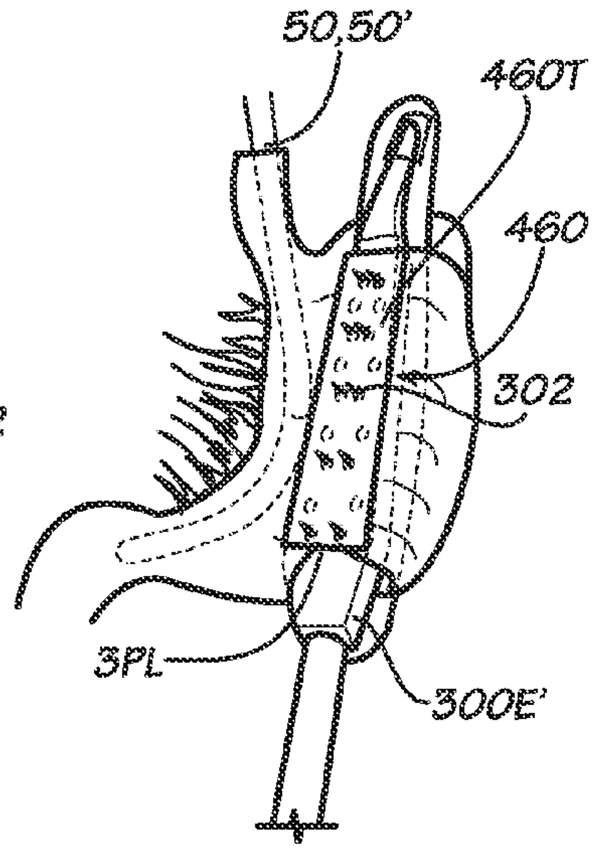

FIG. 10D

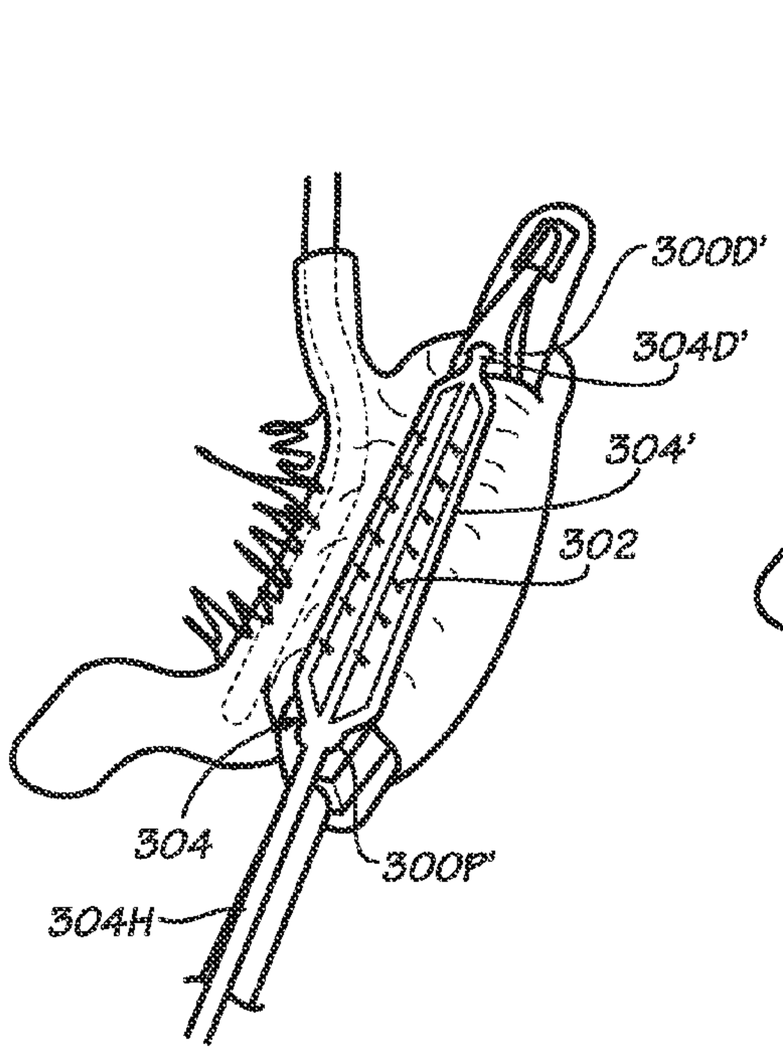

FIG. 10E

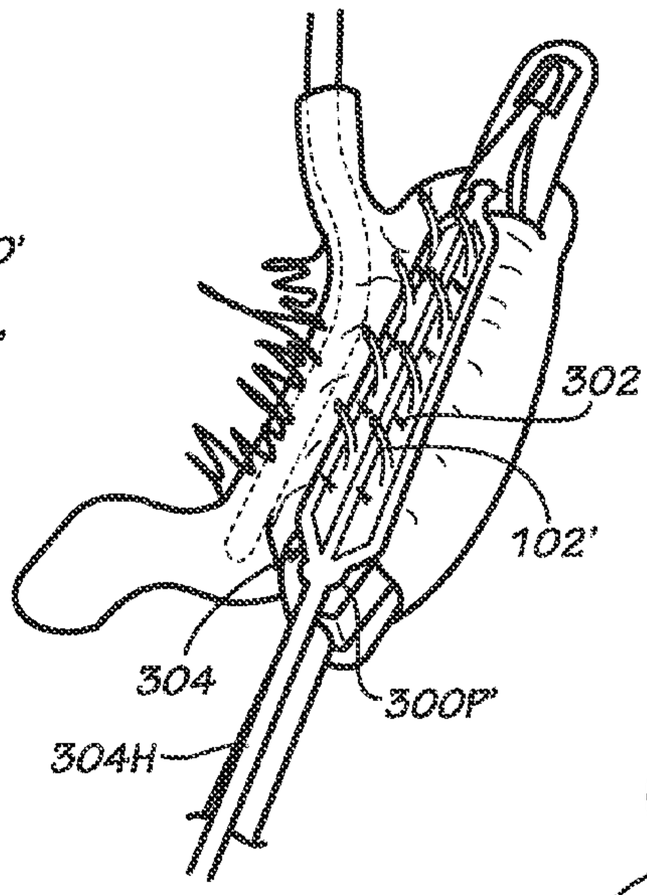

FIG. 10F

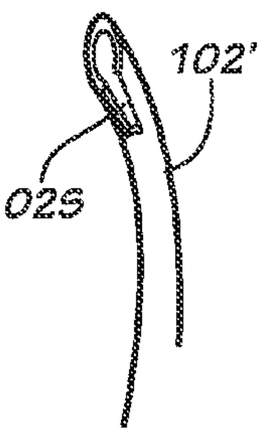

FIG. 10F'

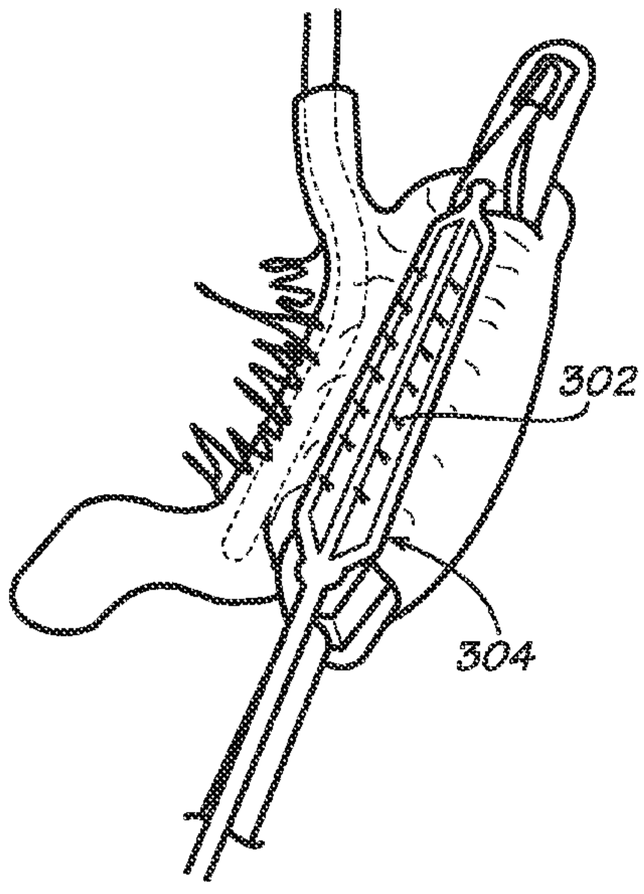

FIG. 10G

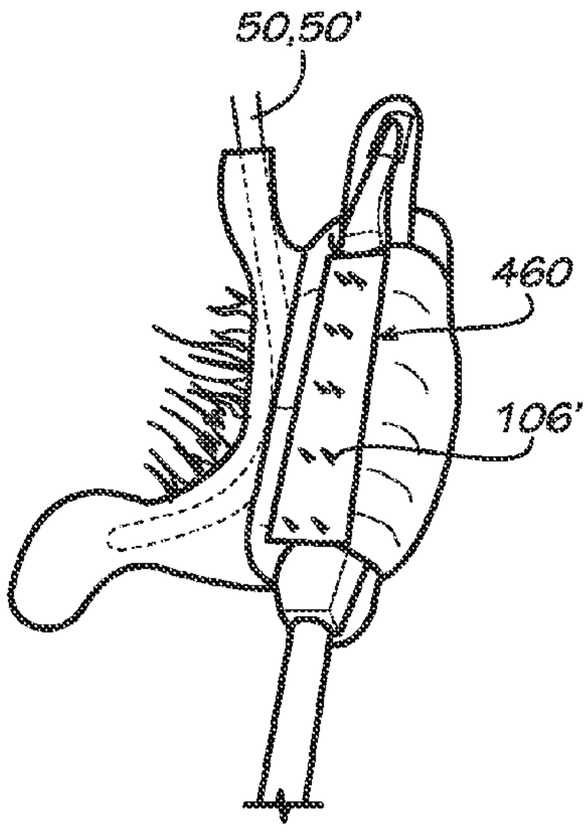

FIG. 10H

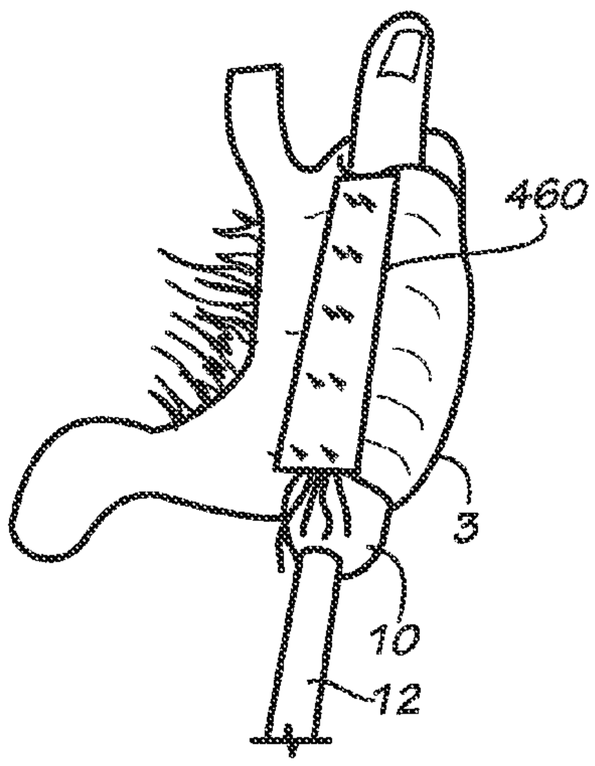

FIG. 10I

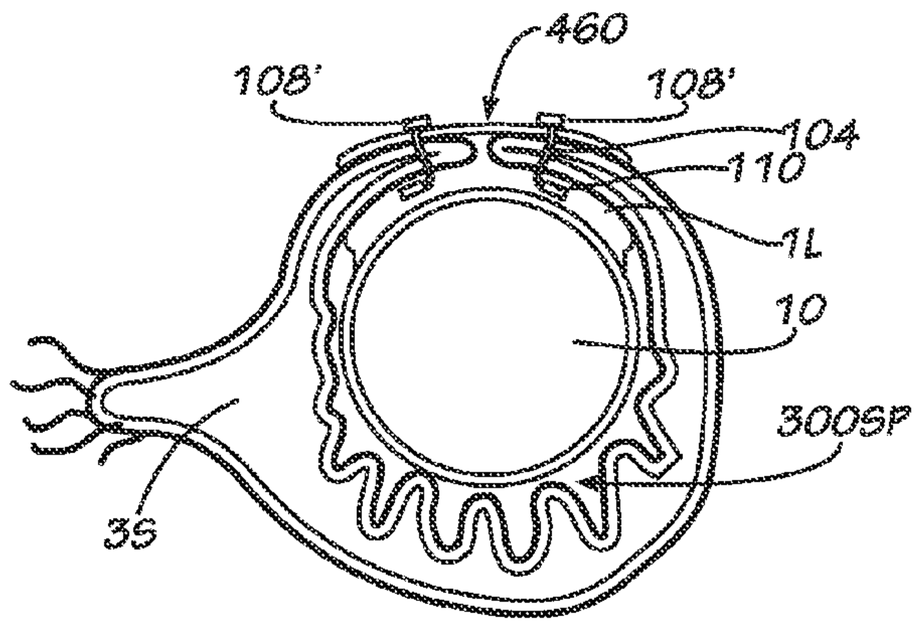

FIG. 10J

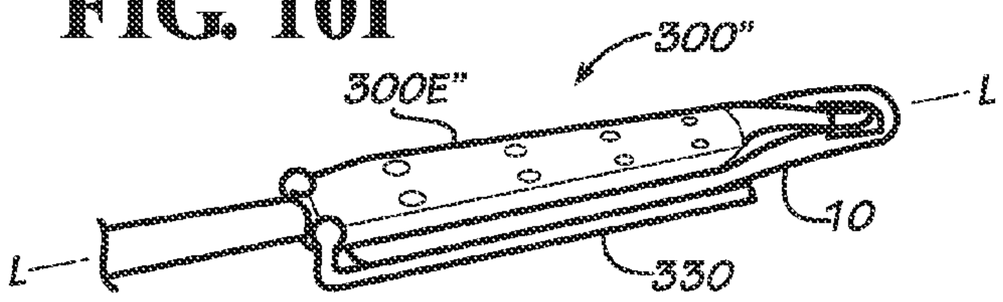

FIG. 11A

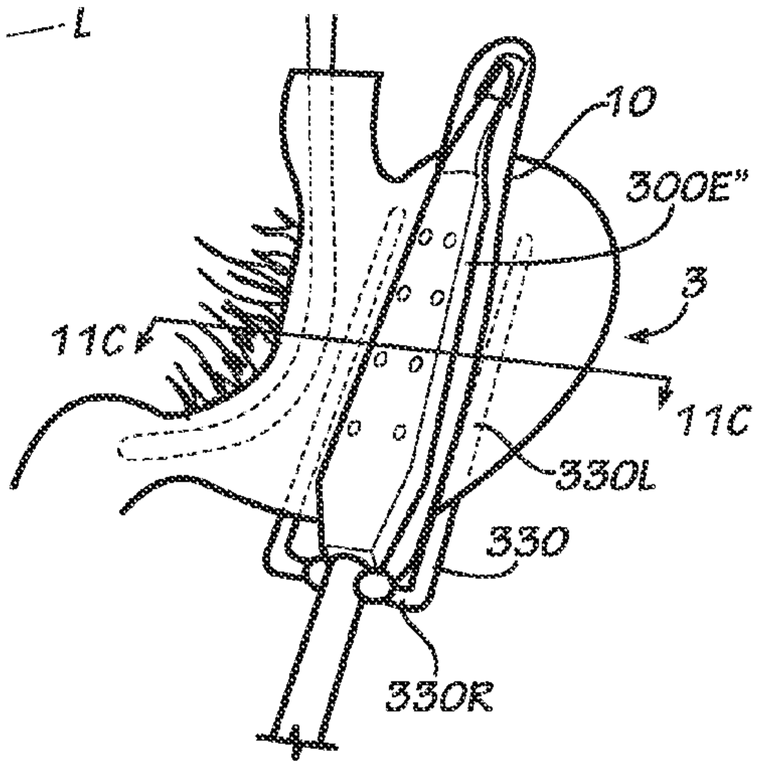

FIG. 11B

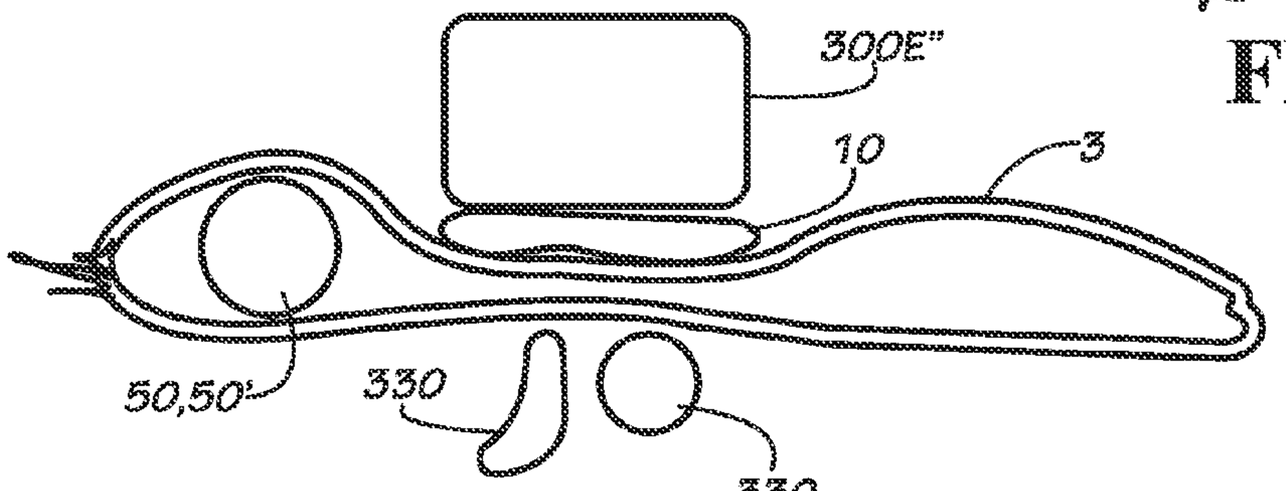

FIG. 11C

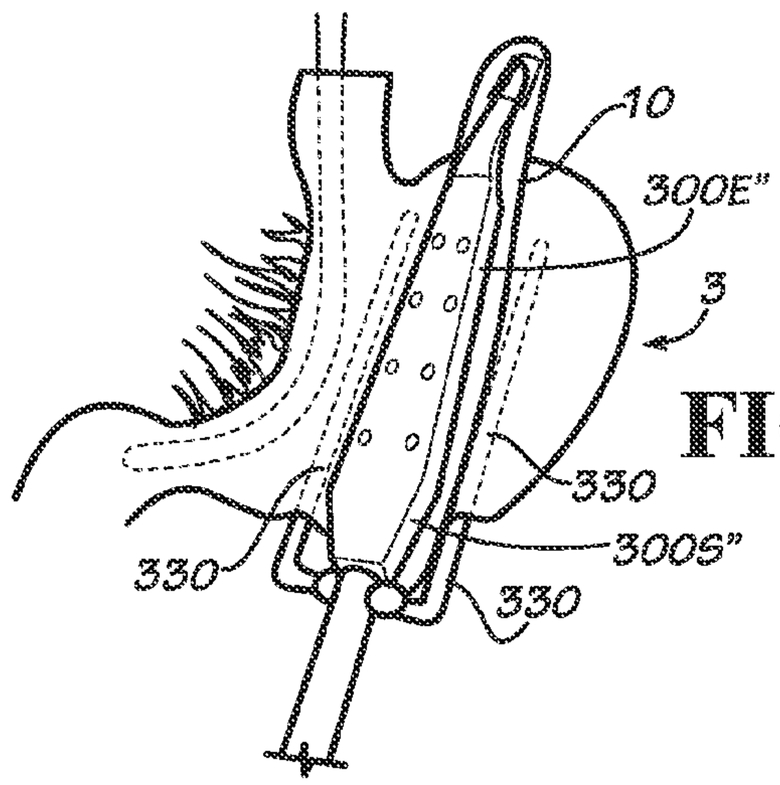

FIG. 11D

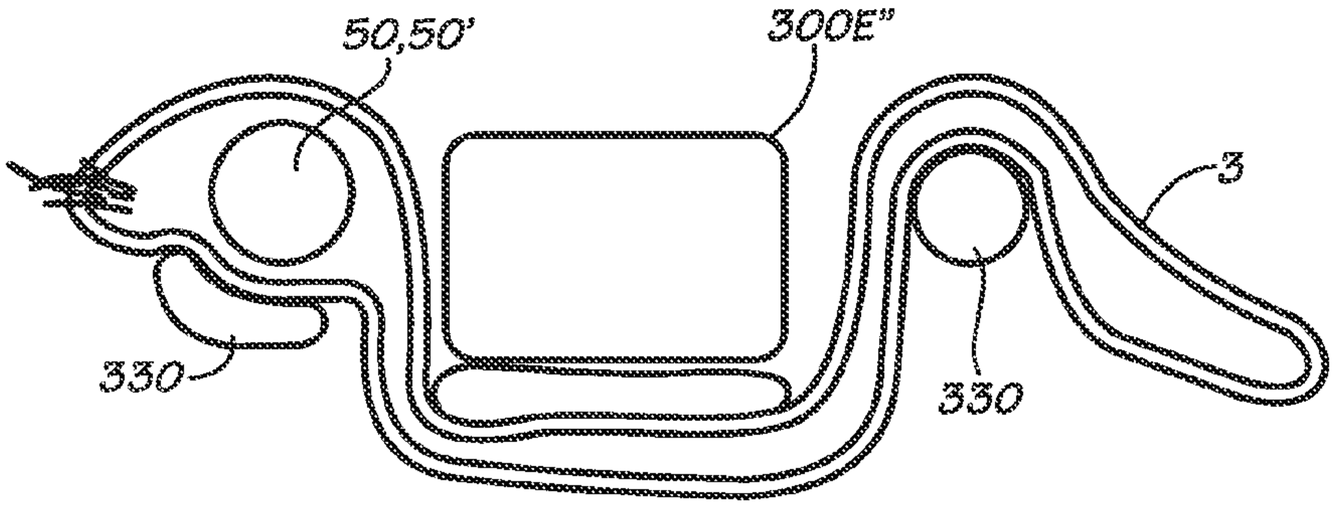

FIG. 11E

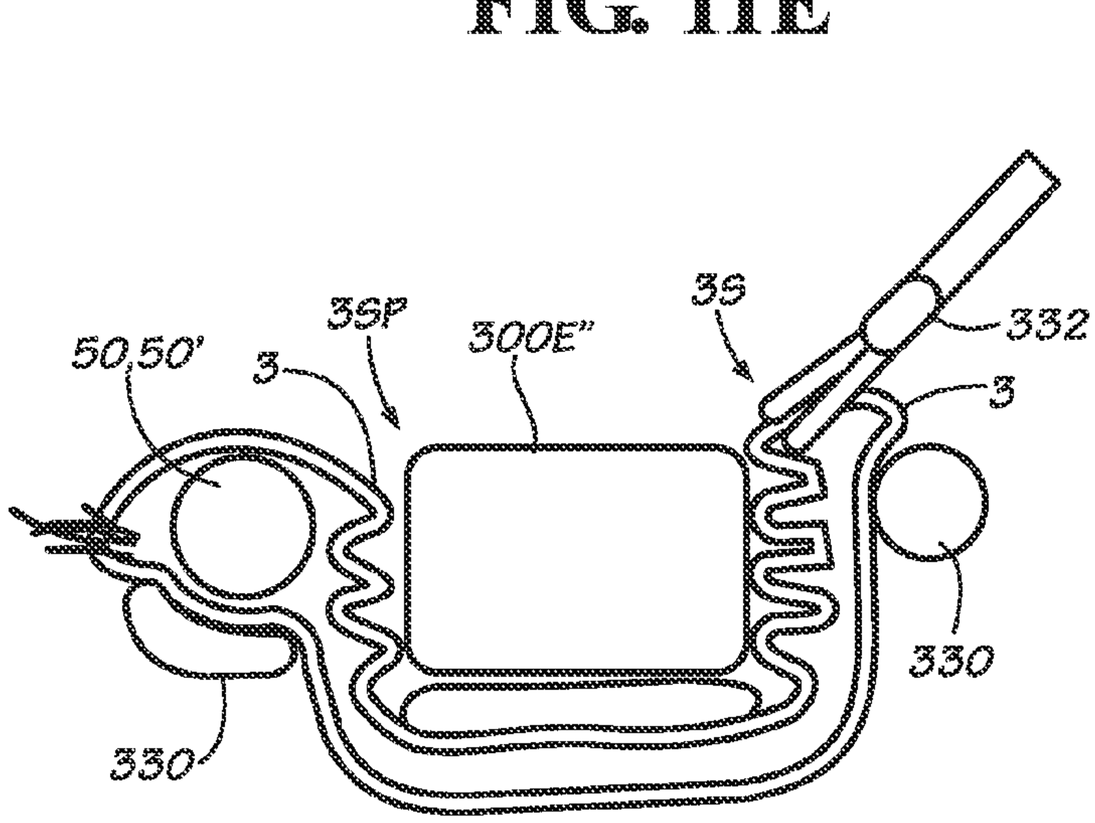

FIG. 11F

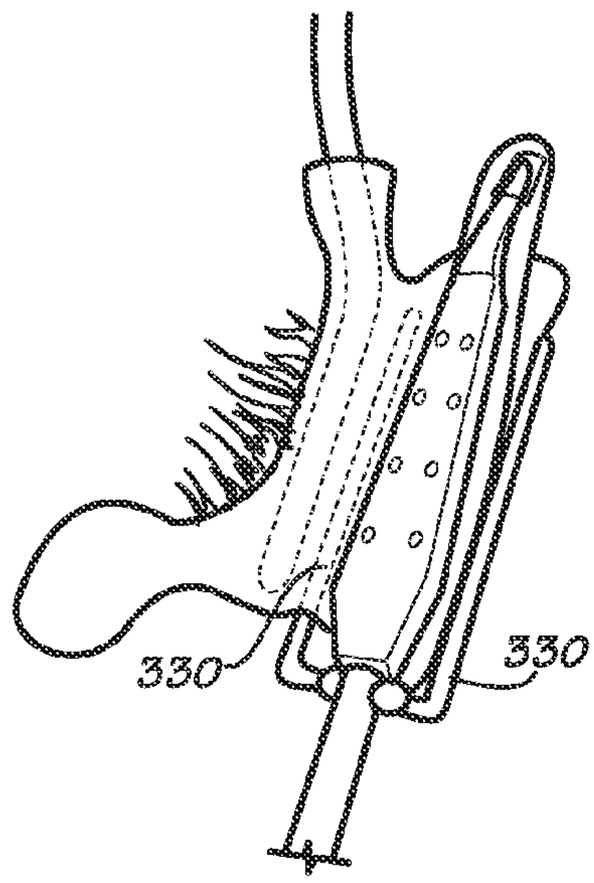

FIG. 11G

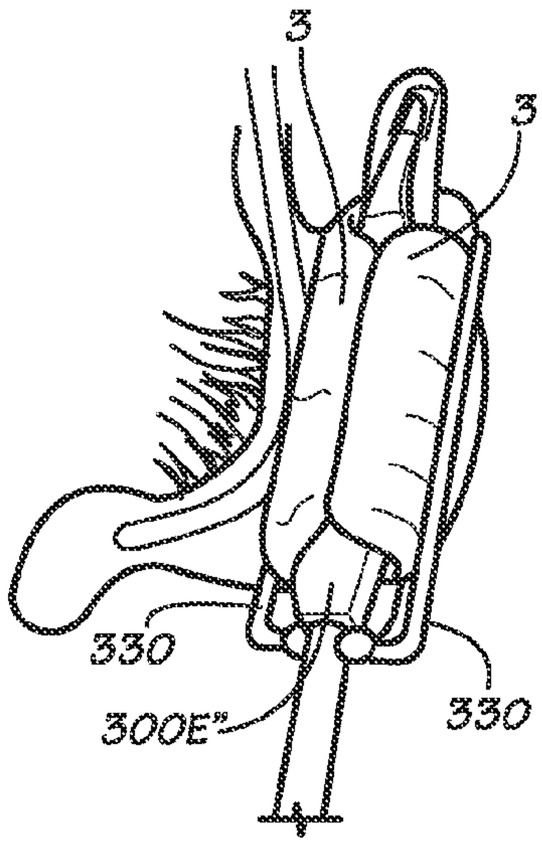

FIG. 11H

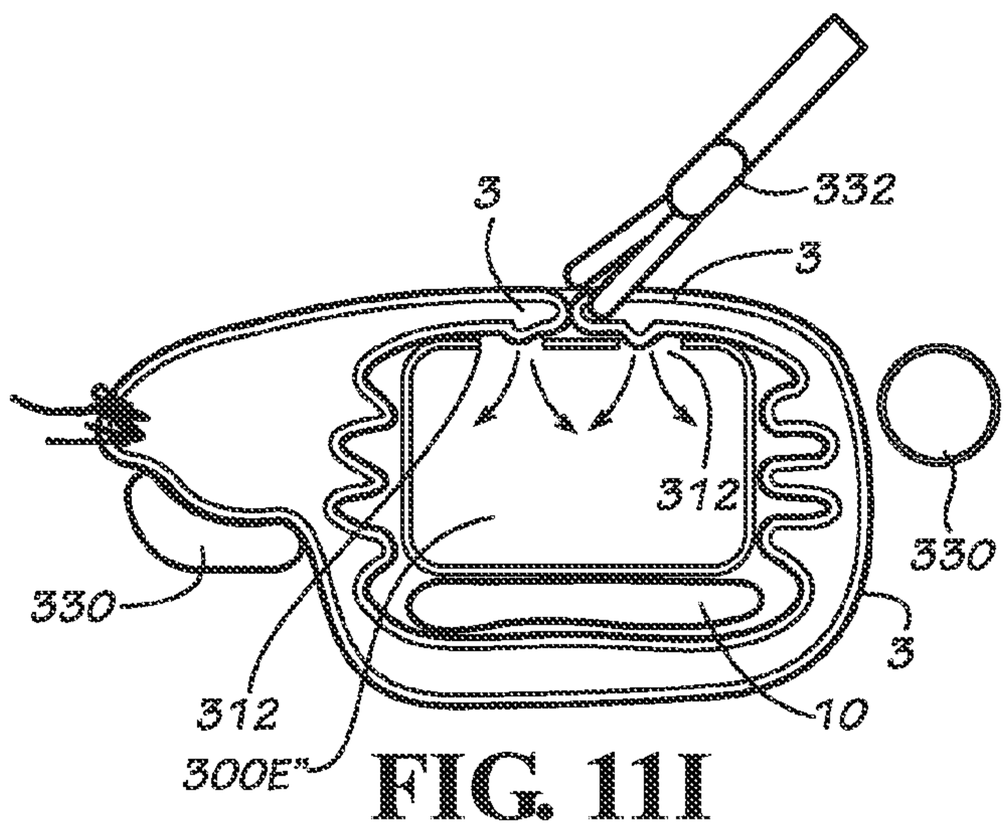

FIG. 11I

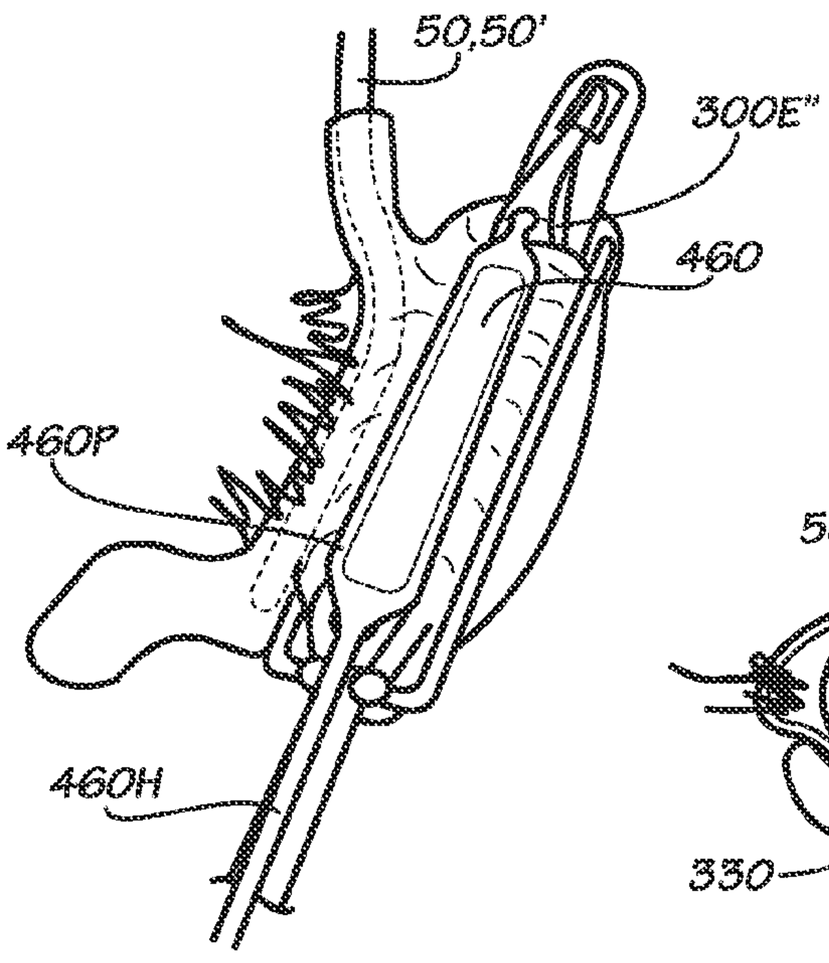

FIG. 11J

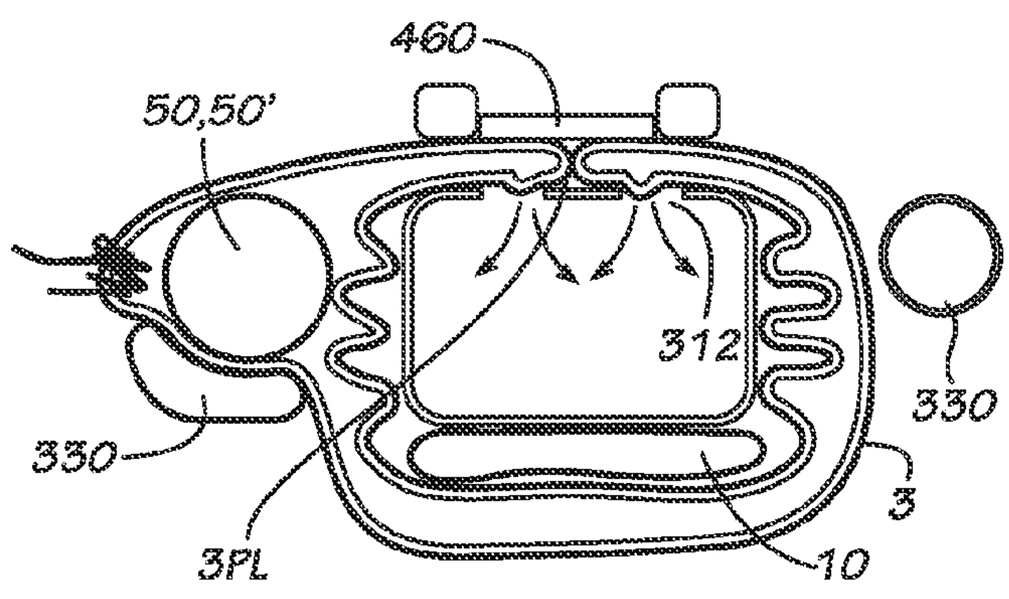

FIG. 11K

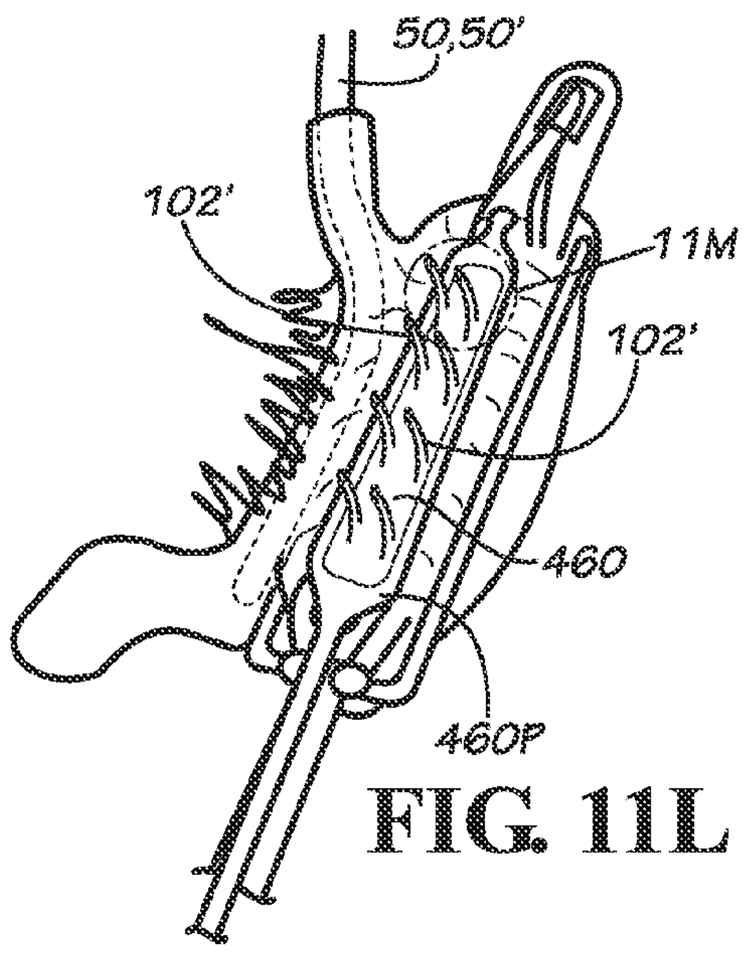

FIG. 11L

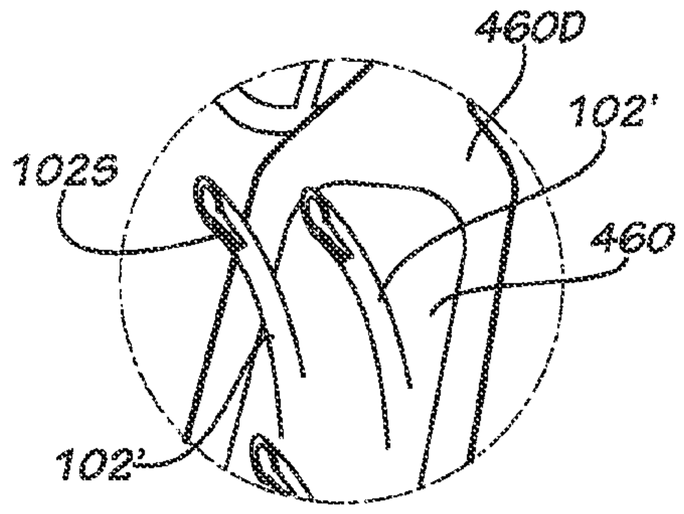

FIG. 11M

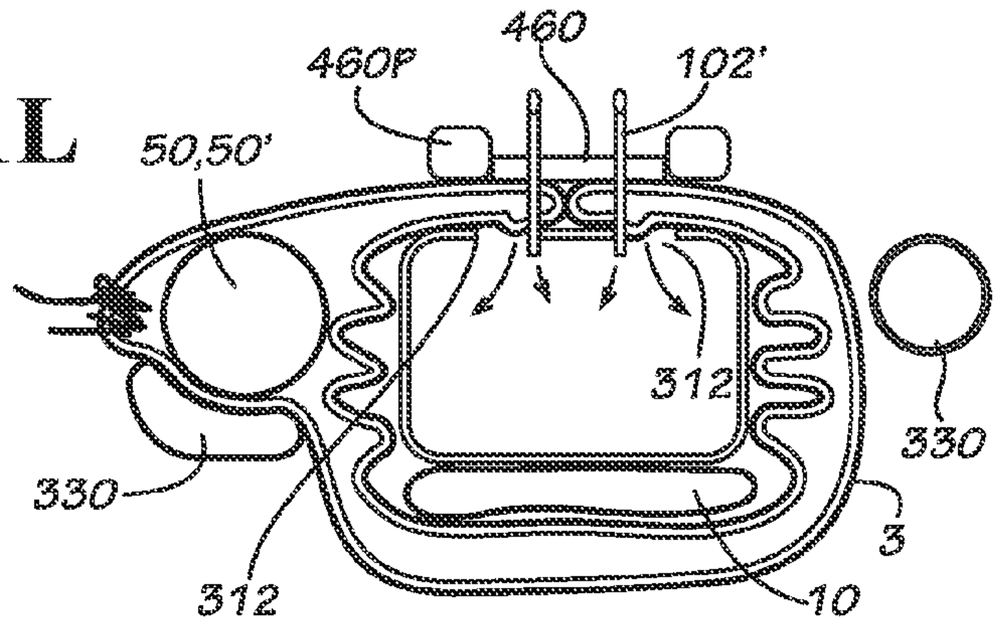

FIG. 11N

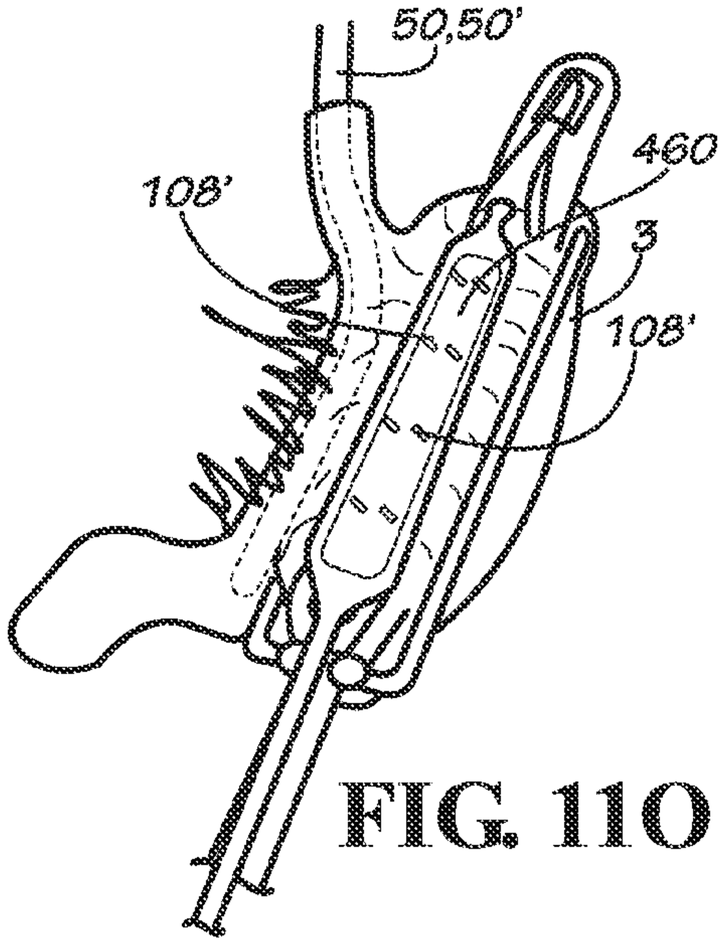

FIG. 11O

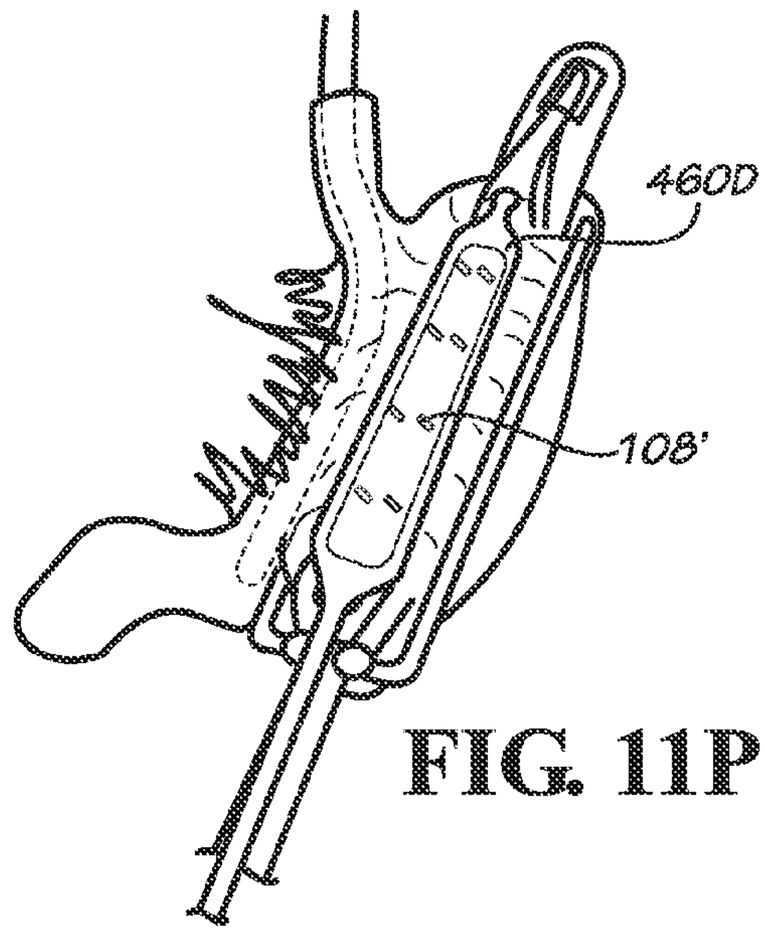

FIG. 11P

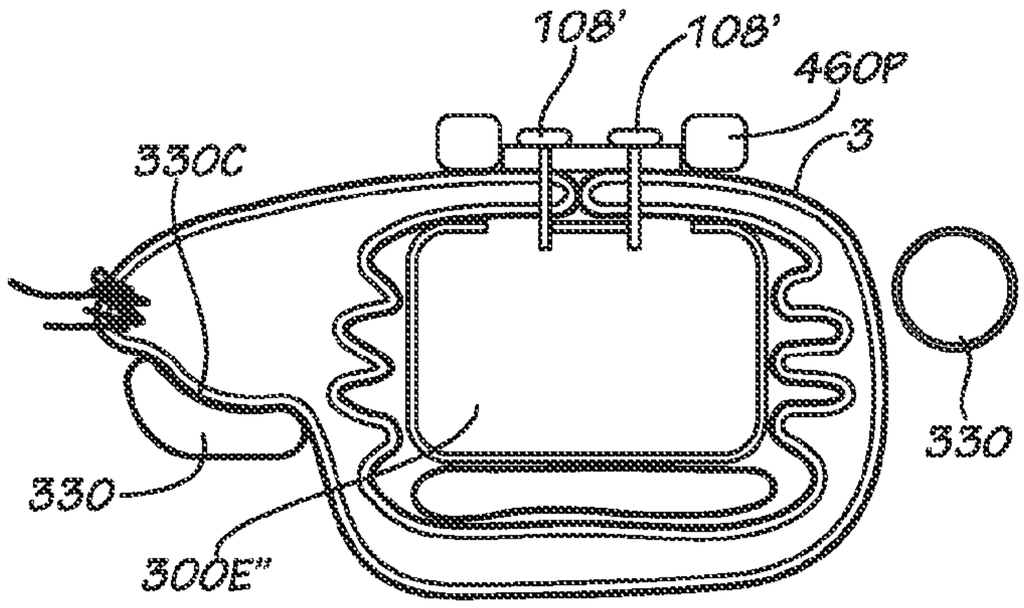

FIG. 11Q

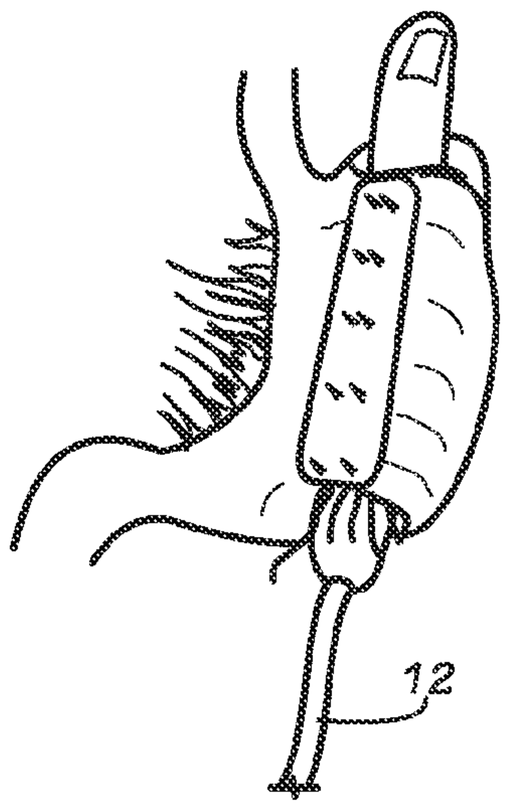

FIG. 11R

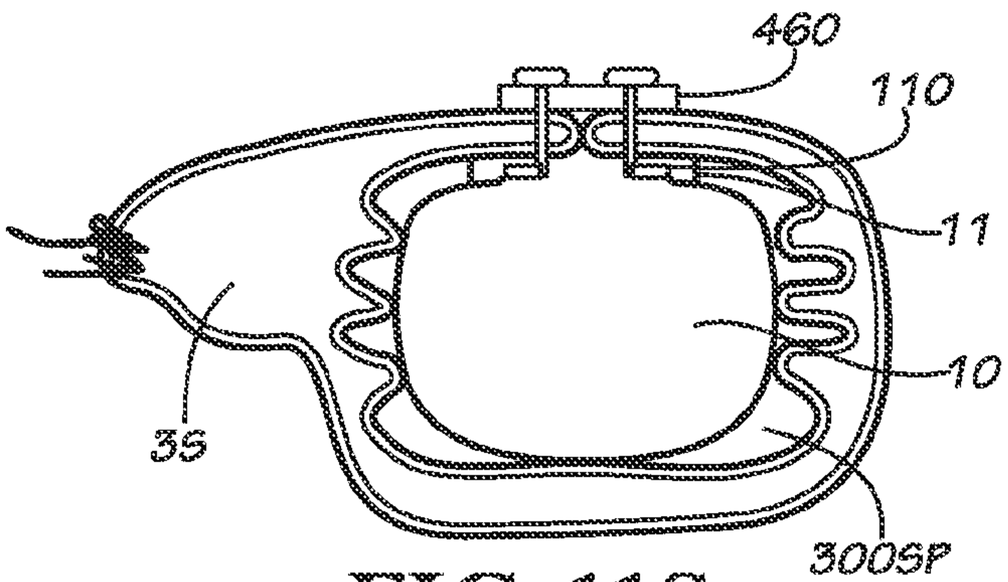

FIG. 11S

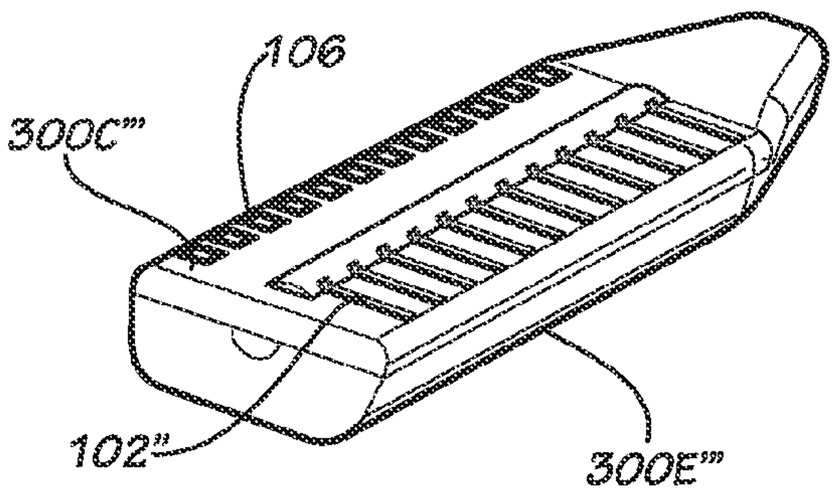

FIG. 12A

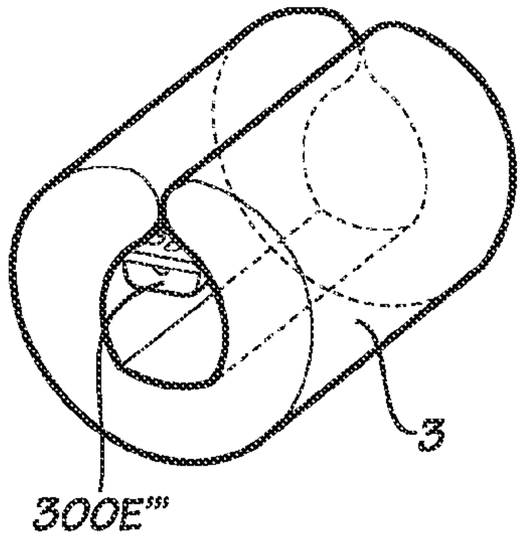

FIG. 12B

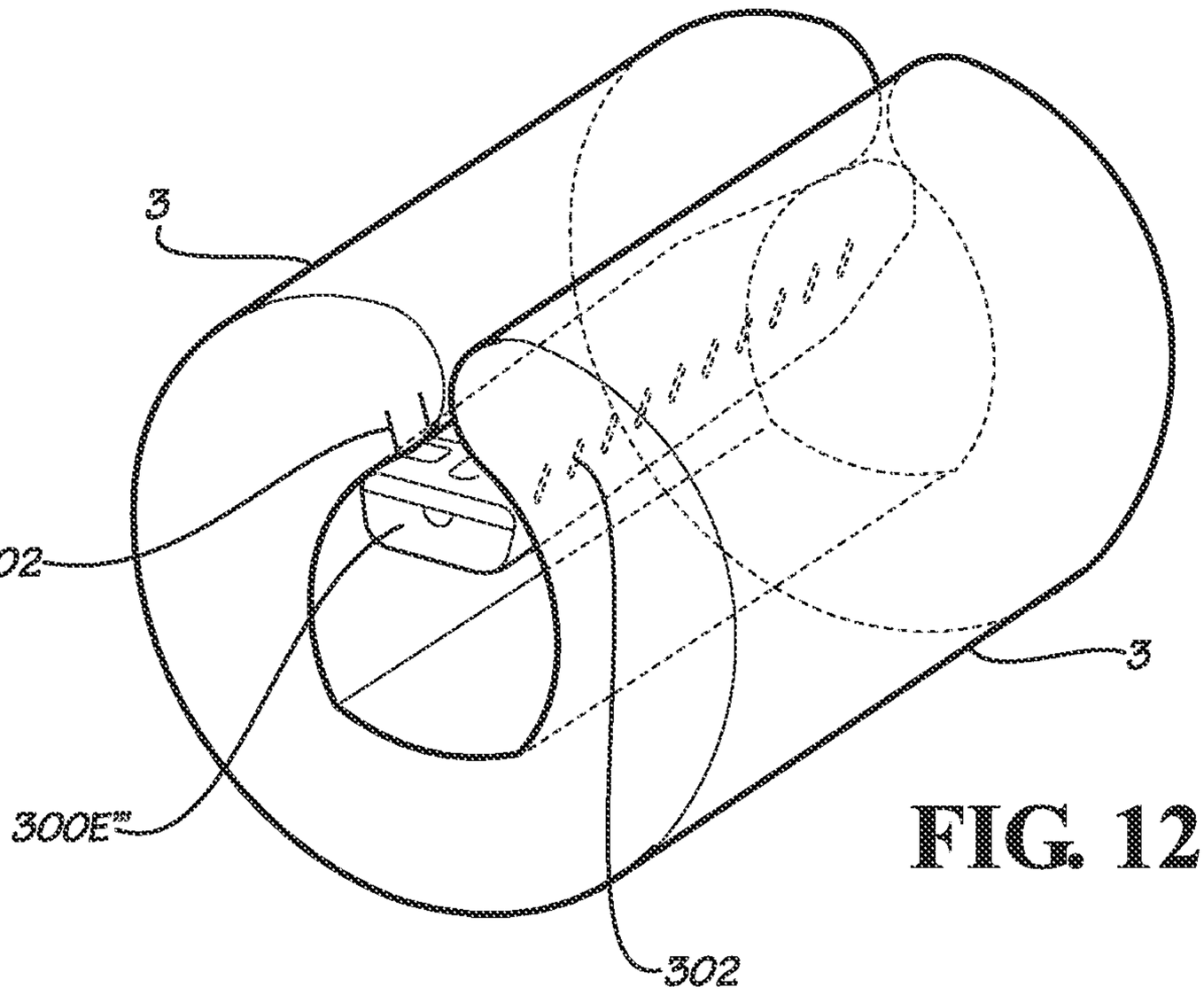

FIG. 12C

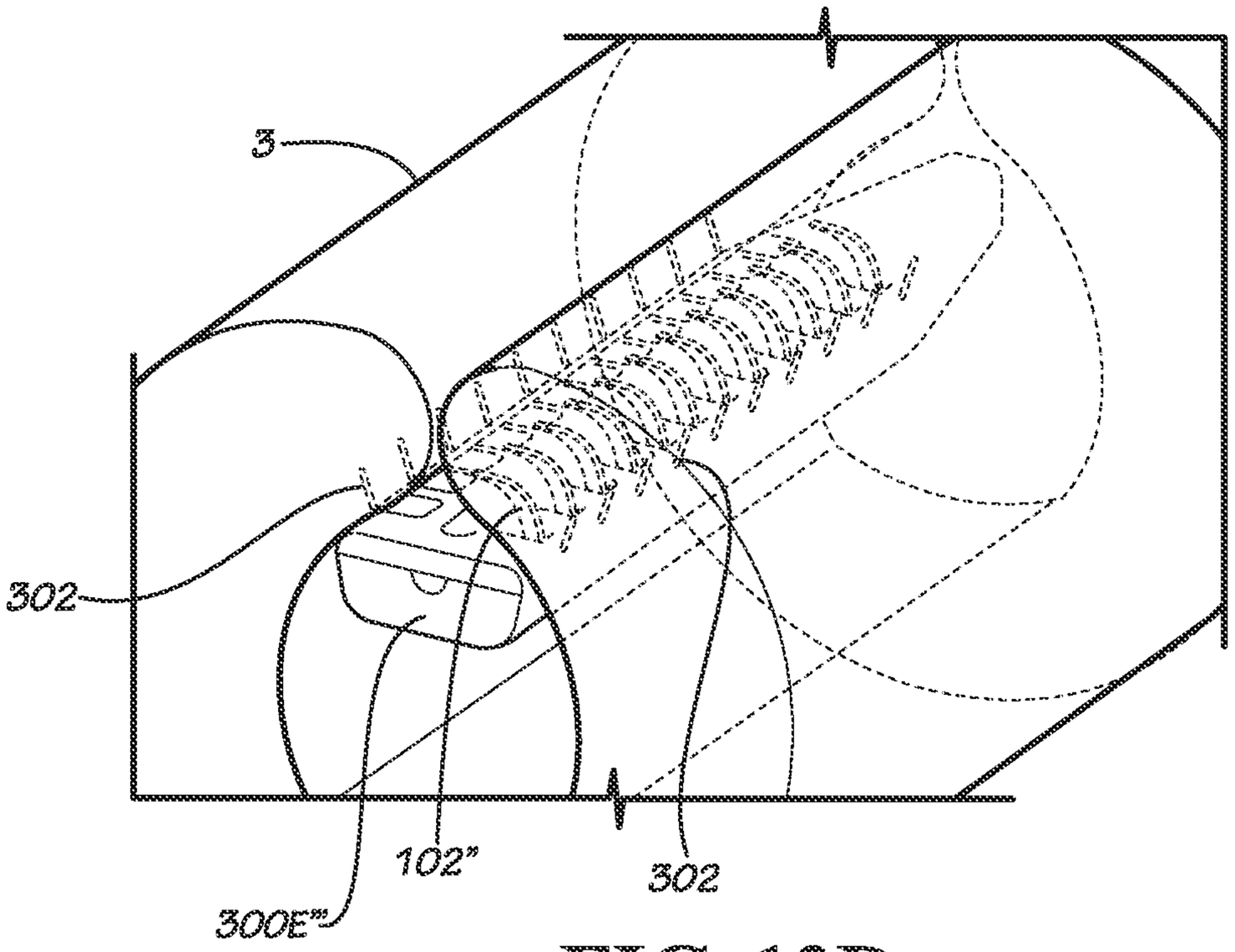

FIG. 12D

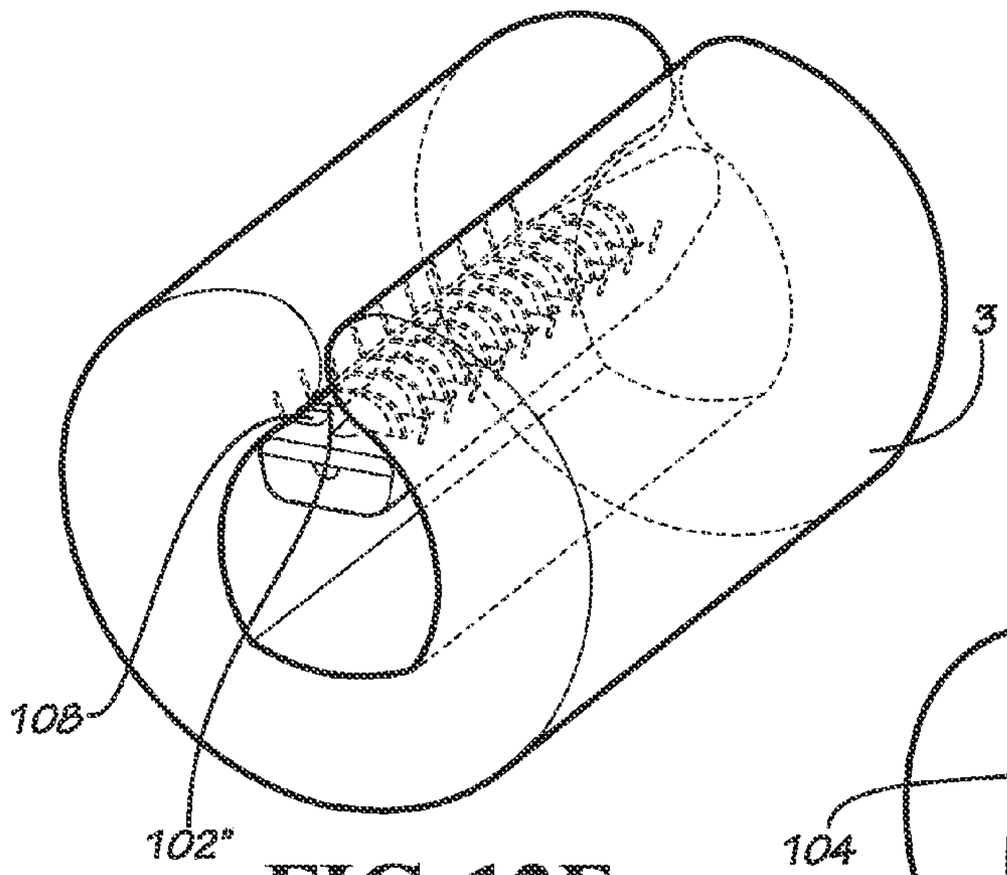

FIG. 12E

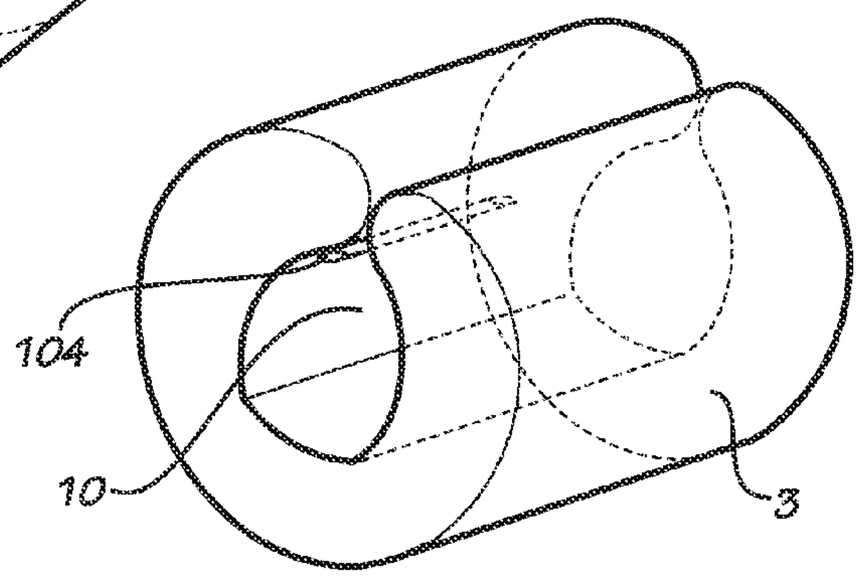

FIG. 12F

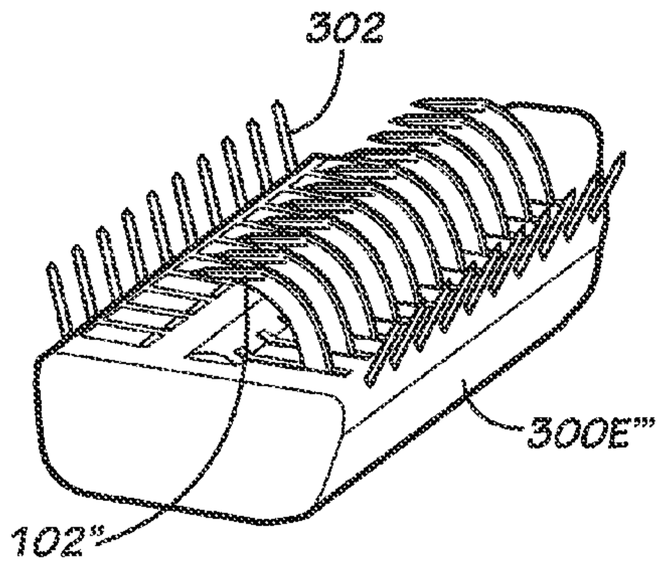

FIG. 12G

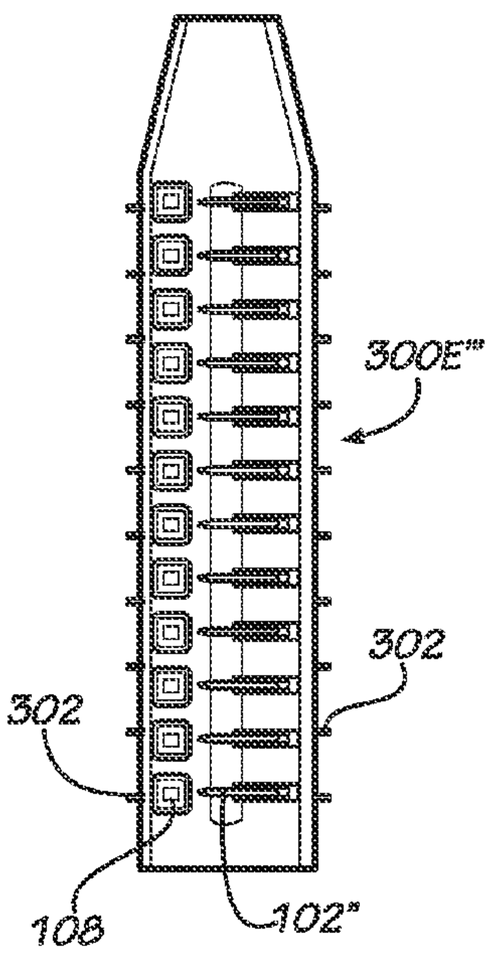

FIG. 12I

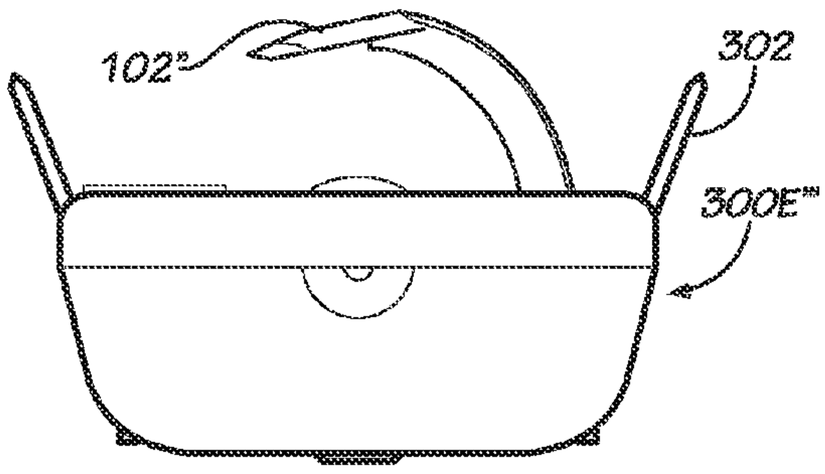

FIG. 12H

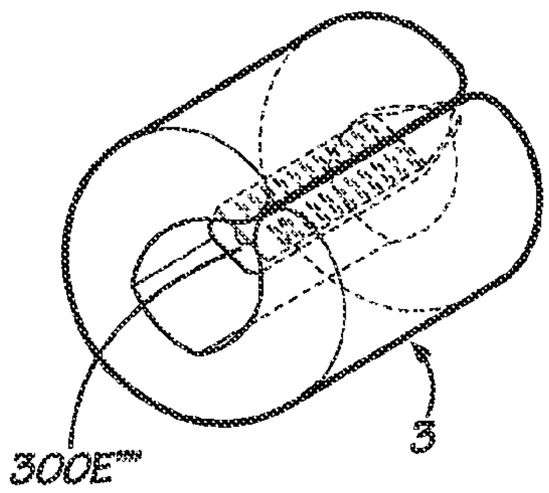

FIG. 13A

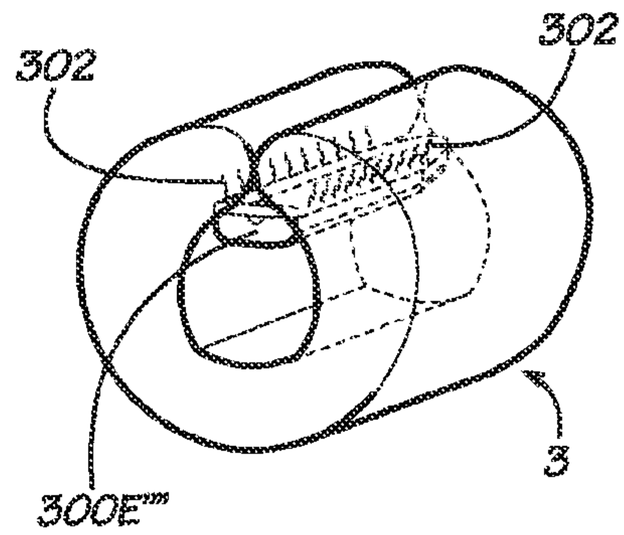

FIG. 13B

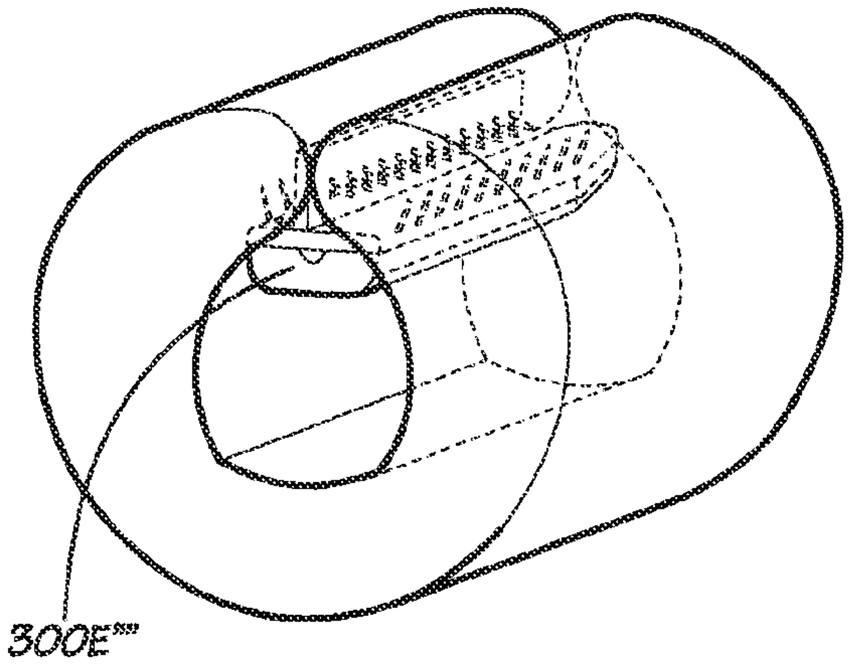

FIG. 13C

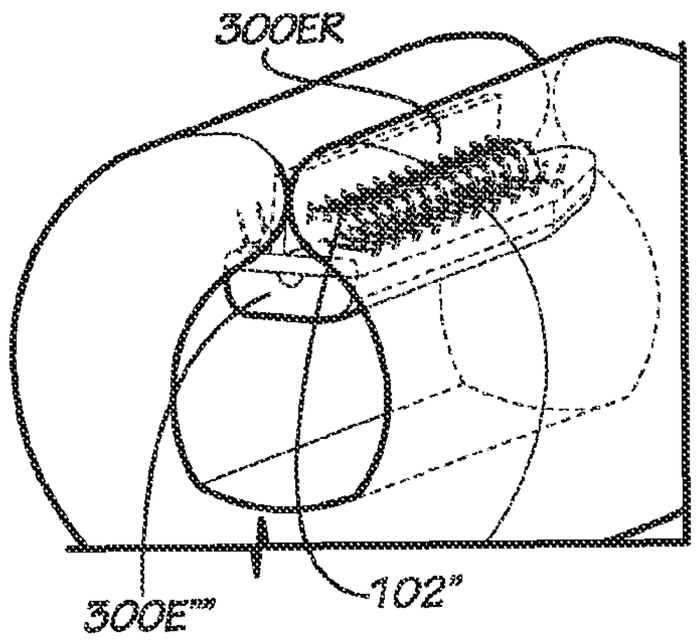

FIG. 13D

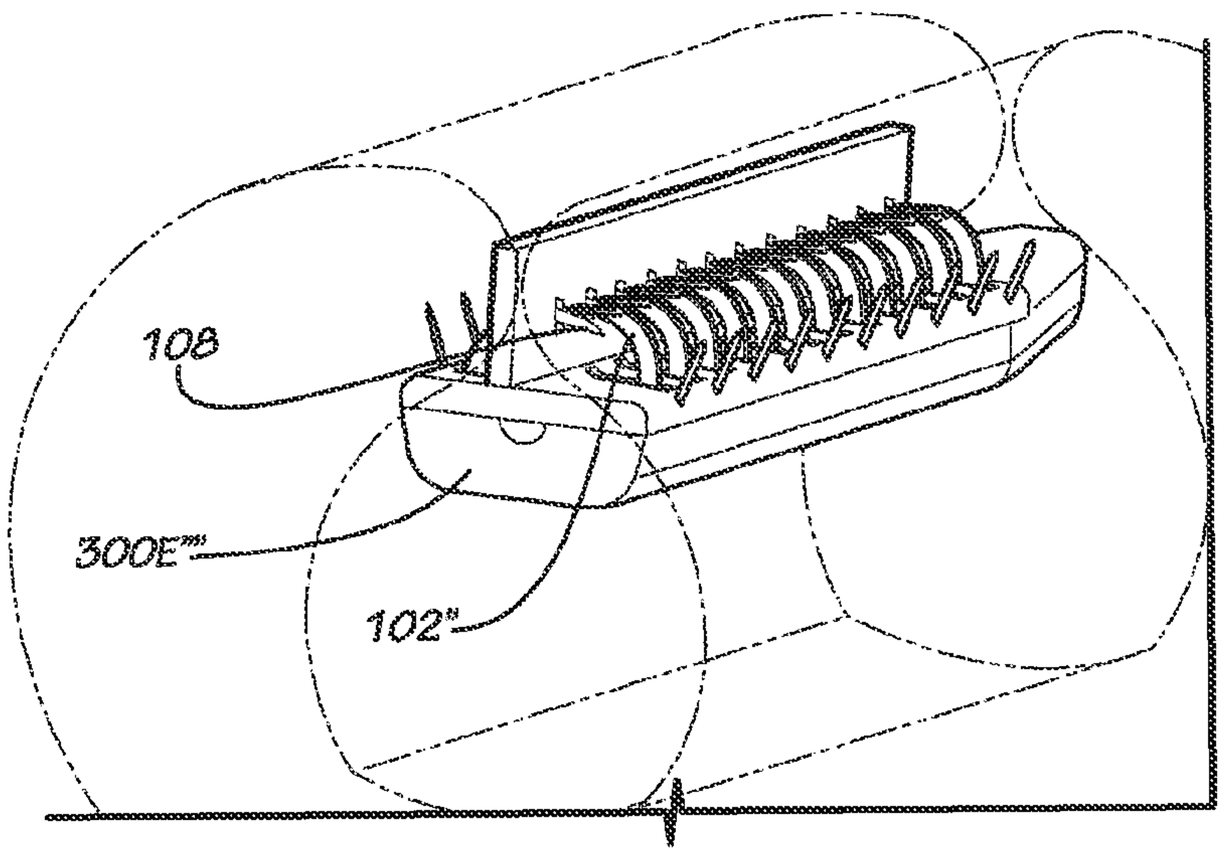

FIG. 13E

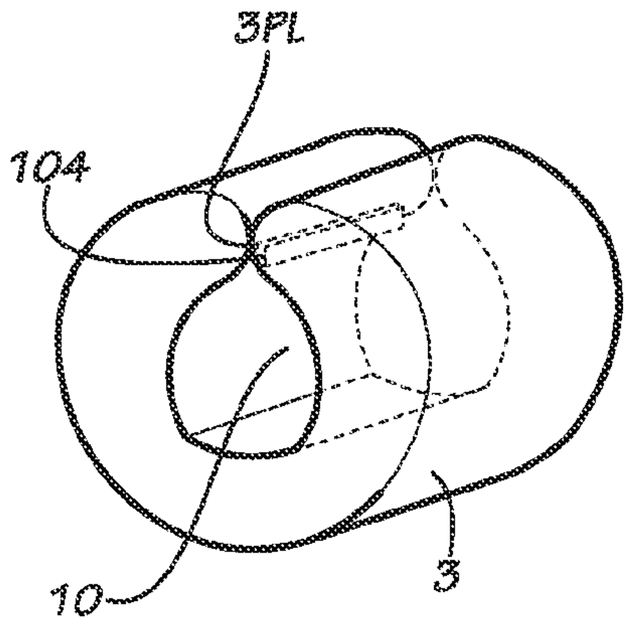

FIG. 13F

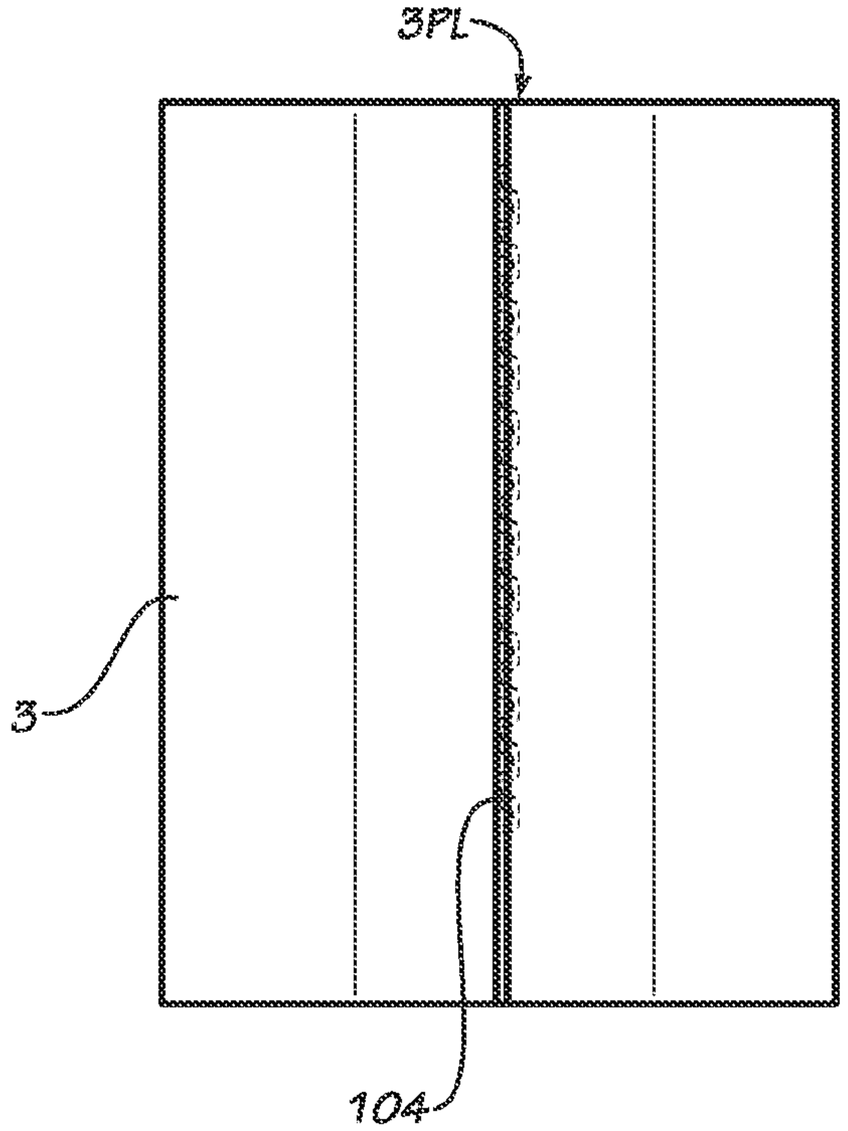

FIG. 13G

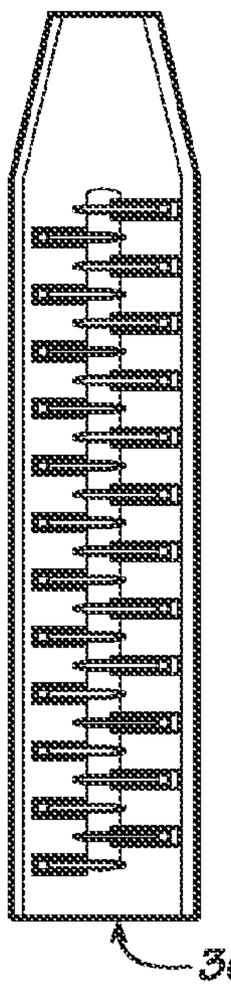

FIG. 14A

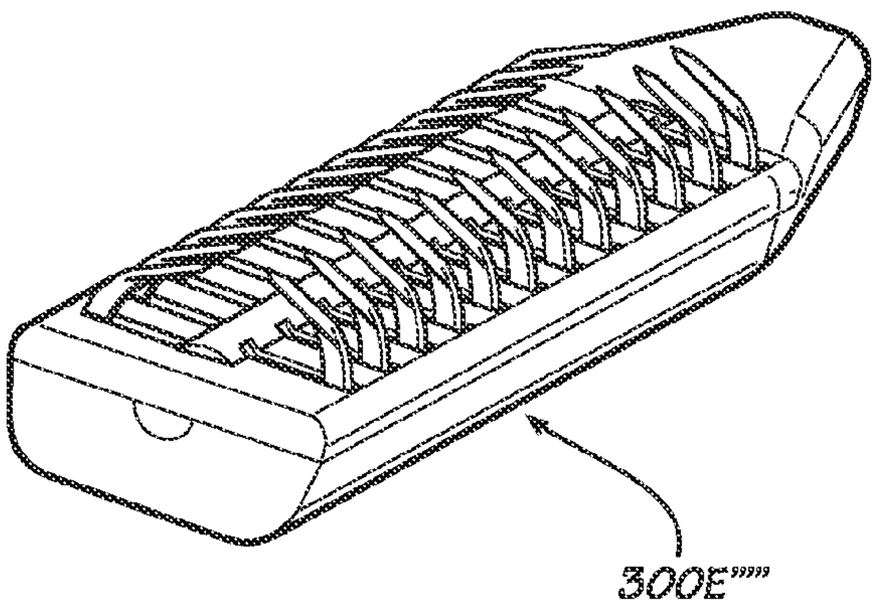

FIG. 14B

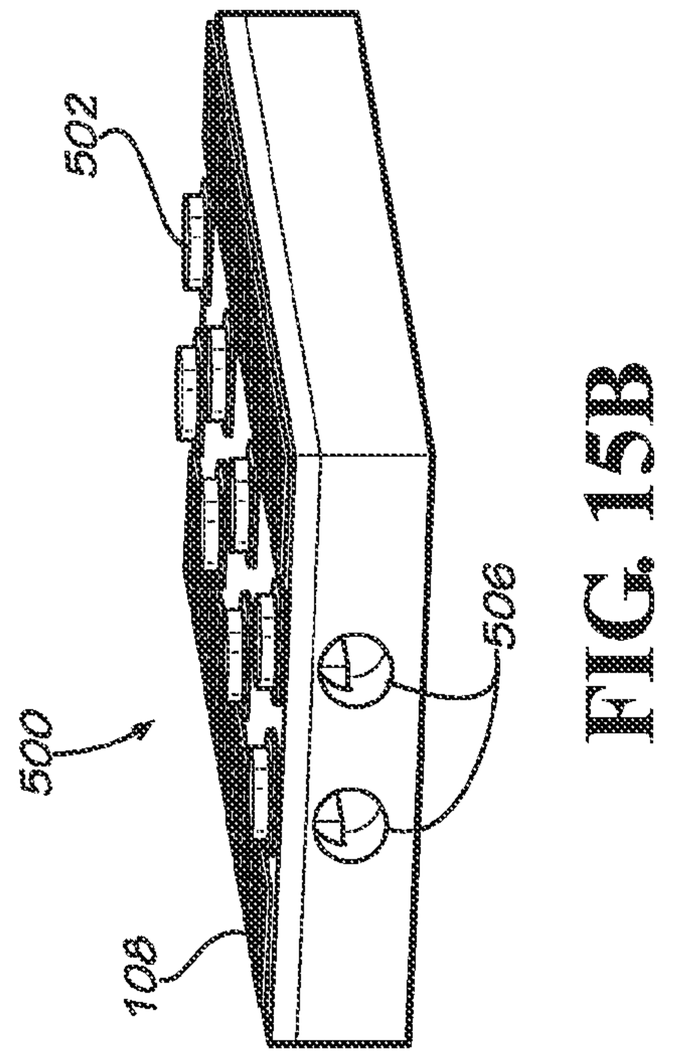

FIG. 15B

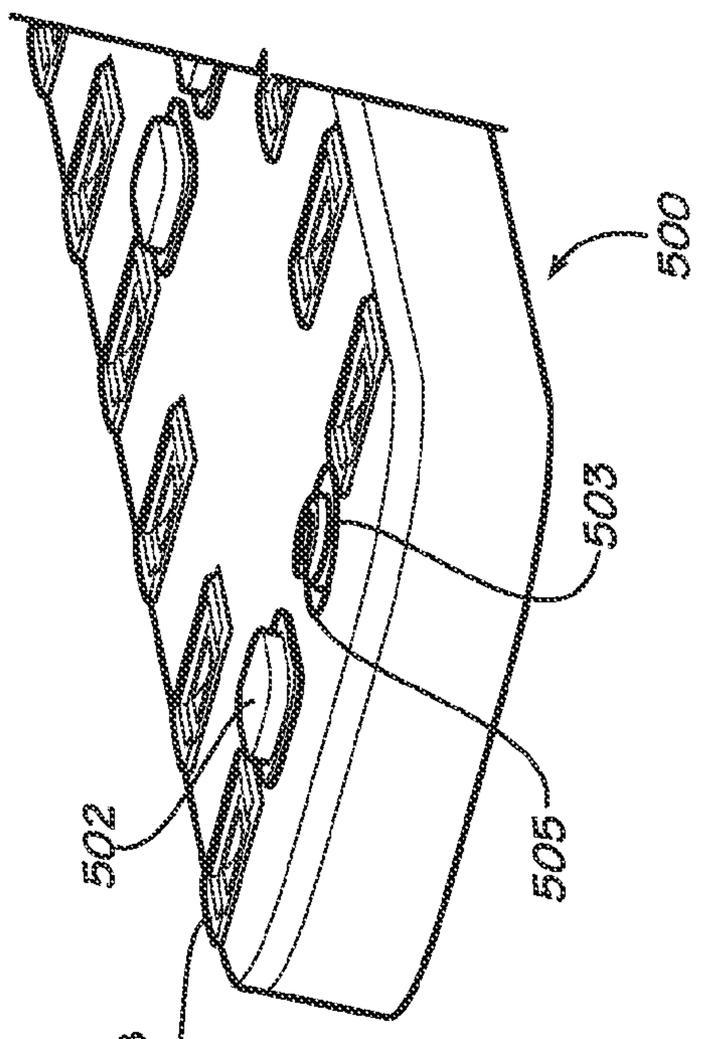

FIG. 15C

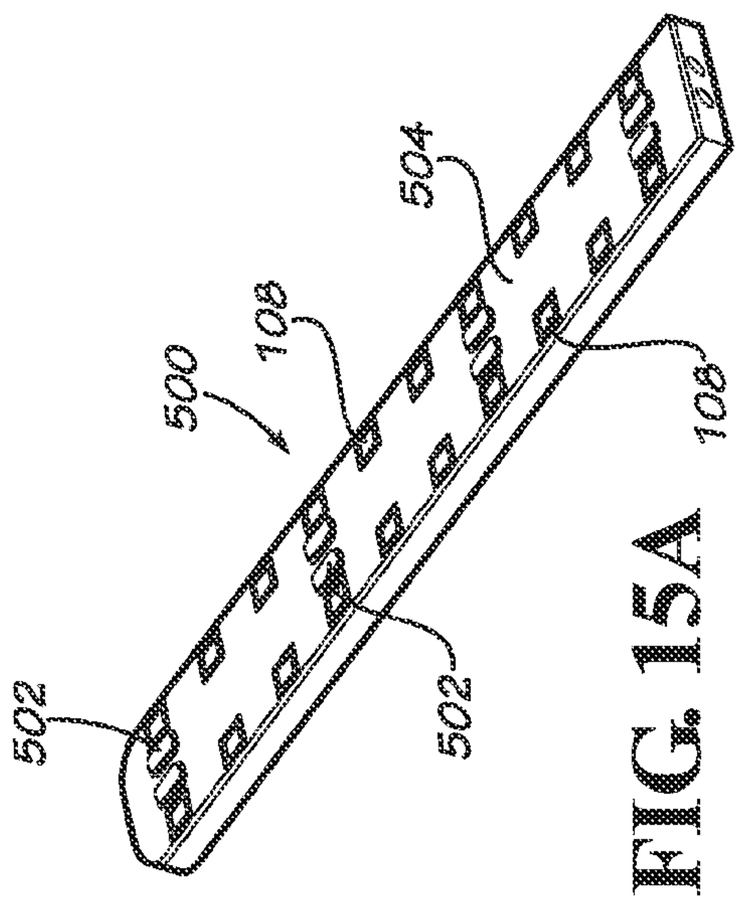

FIG. 15A

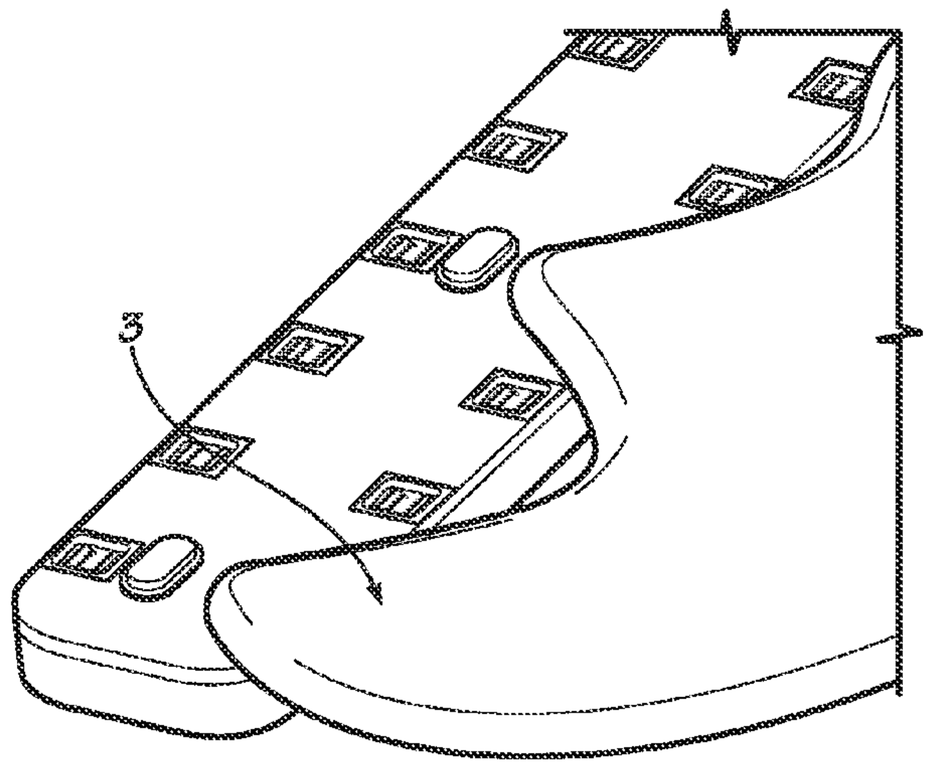

FIG. 15D

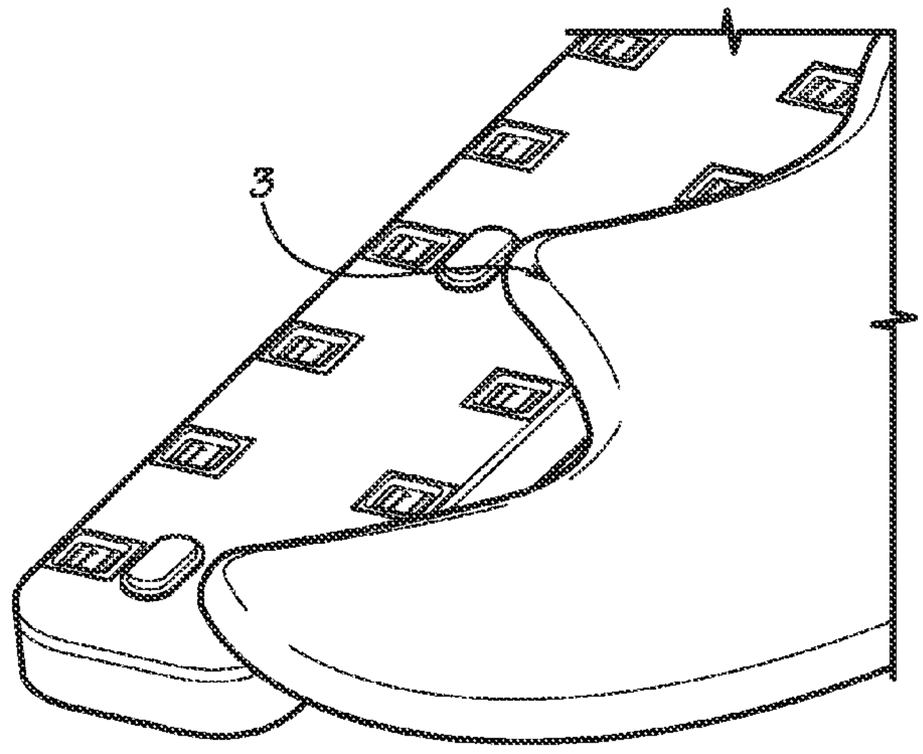

FIG. 15E

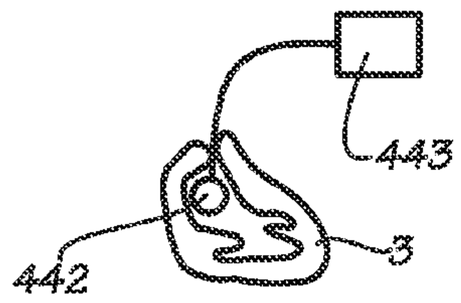

FIG. 16A

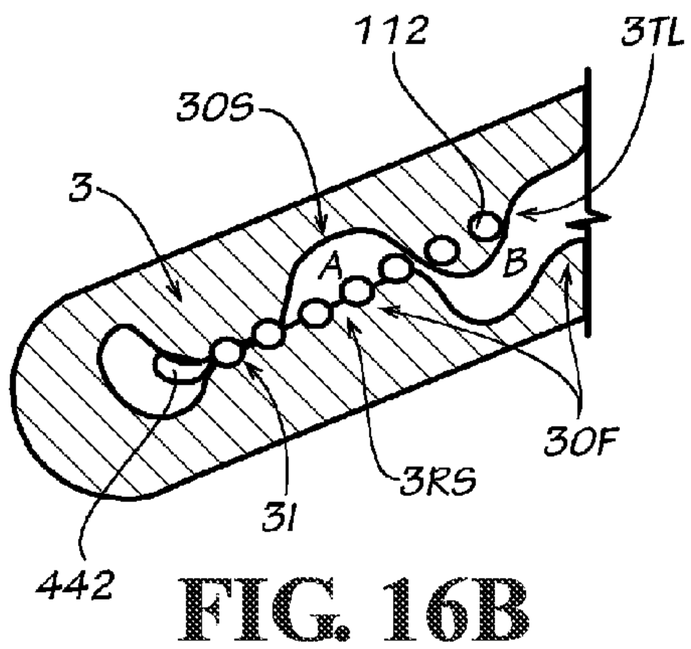

FIG. 16B

FIG. 16C

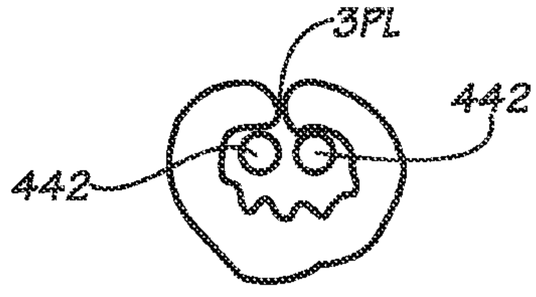

FIG. 16D

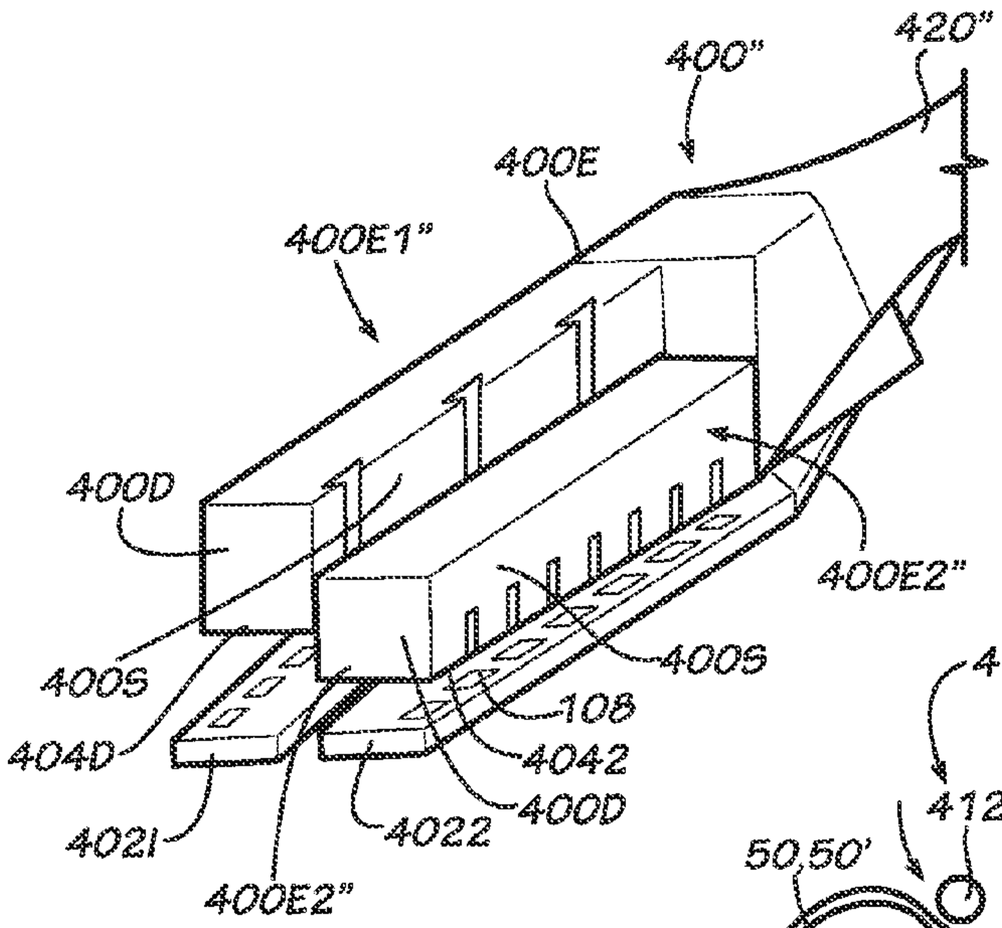

FIG. 17A

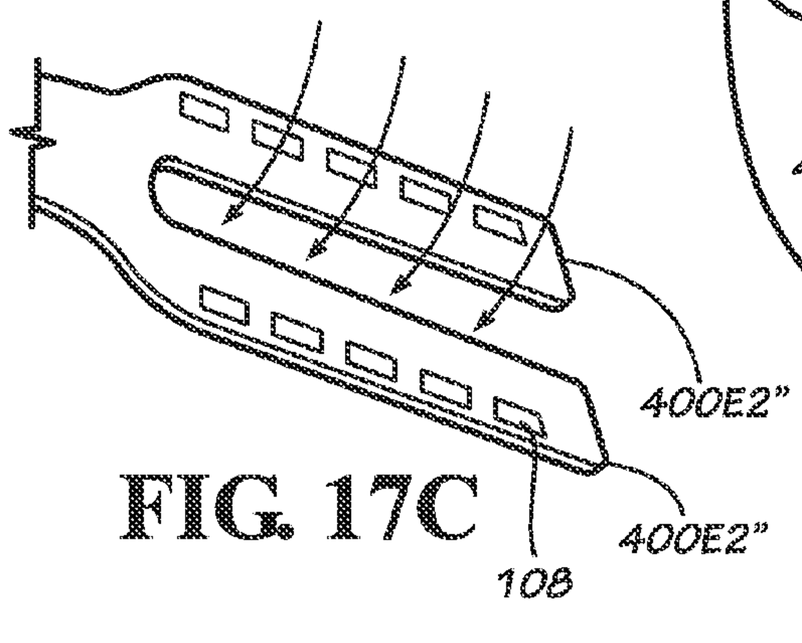

FIG. 17C

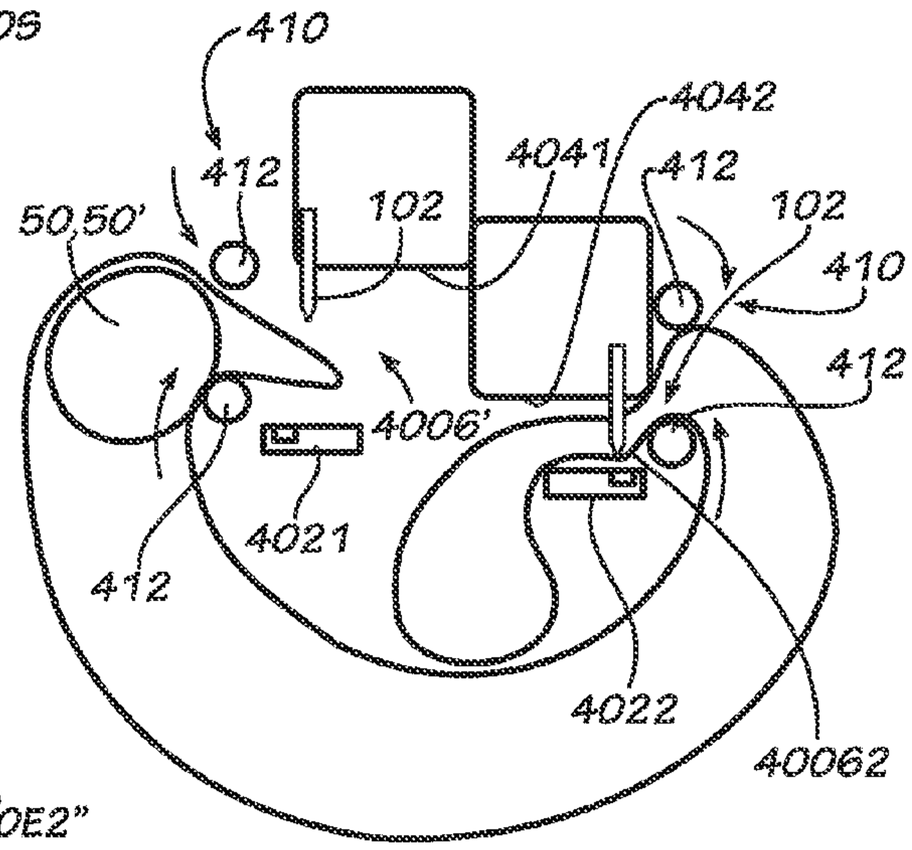

FIG. 17B

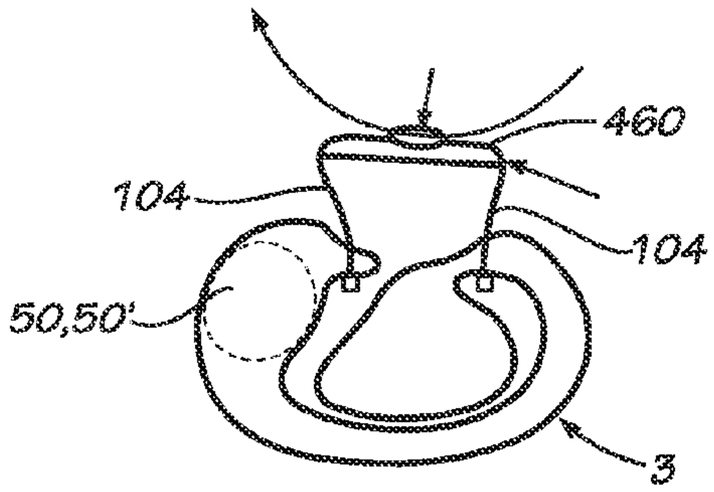

FIG. 17D

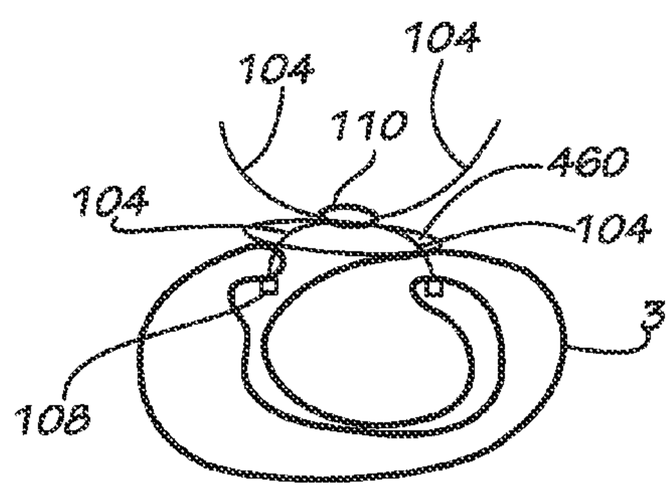

FIG. 17E

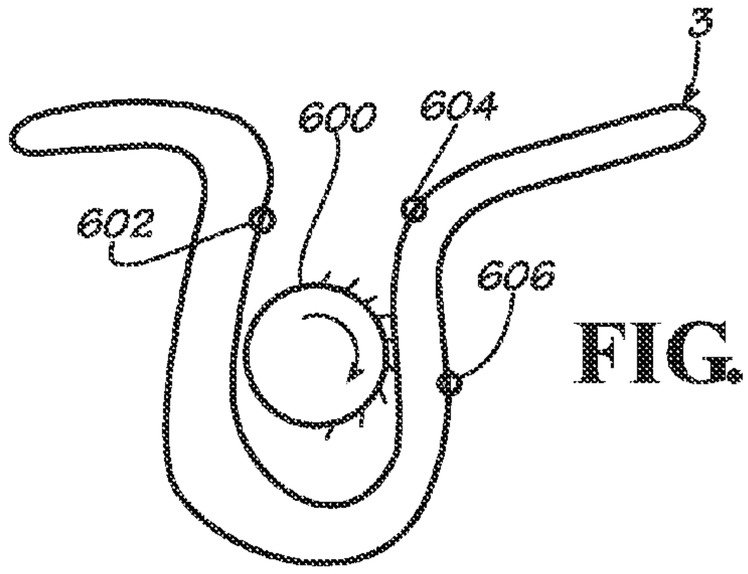

FIG. 18A

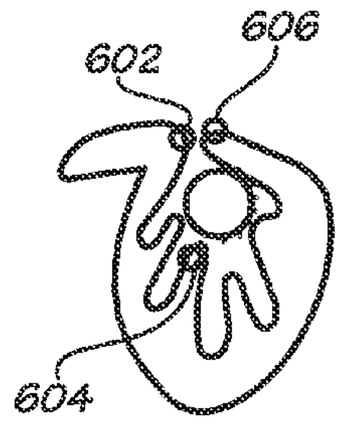

FIG. 18B

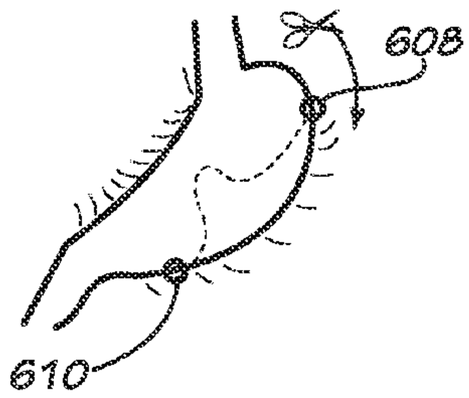

FIG. 18D

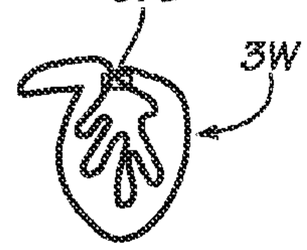

FIG. 18C

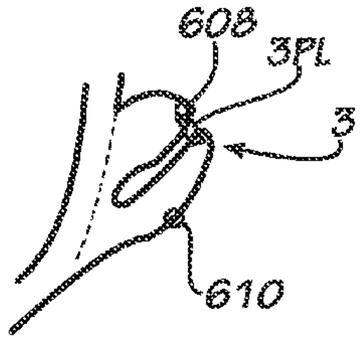

FIG. 18F

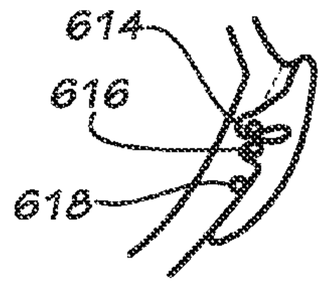

FIG. 18G

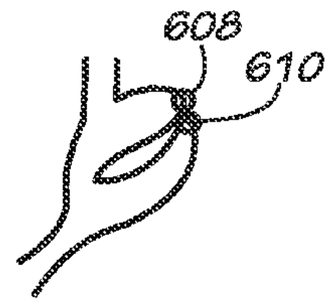

FIG. 18E

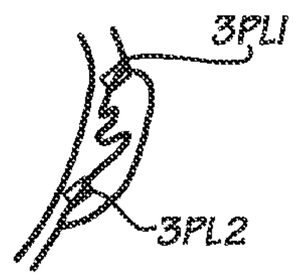

FIG. 18H

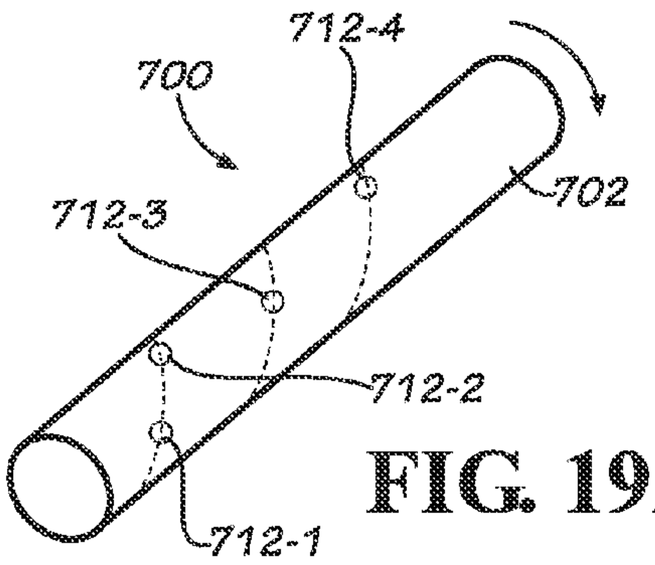

FIG. 19A

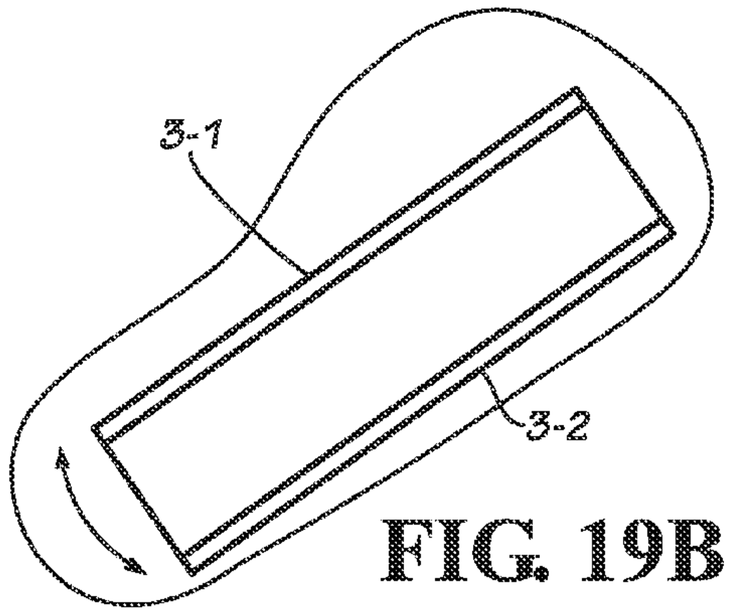

FIG. 19B

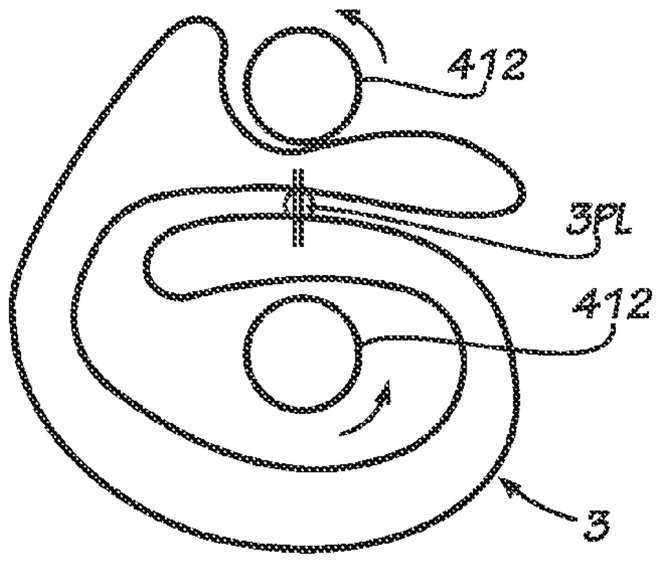

FIG. 20A

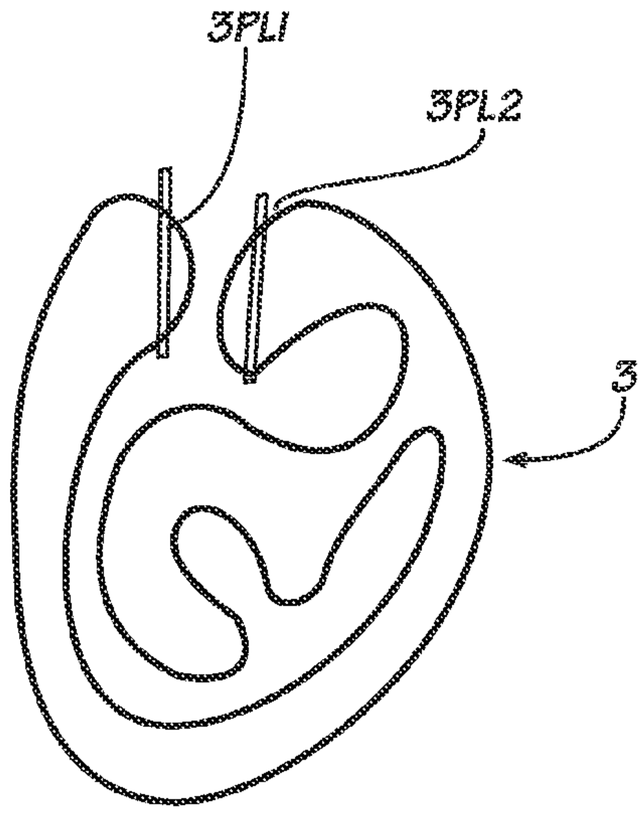

FIG. 20B

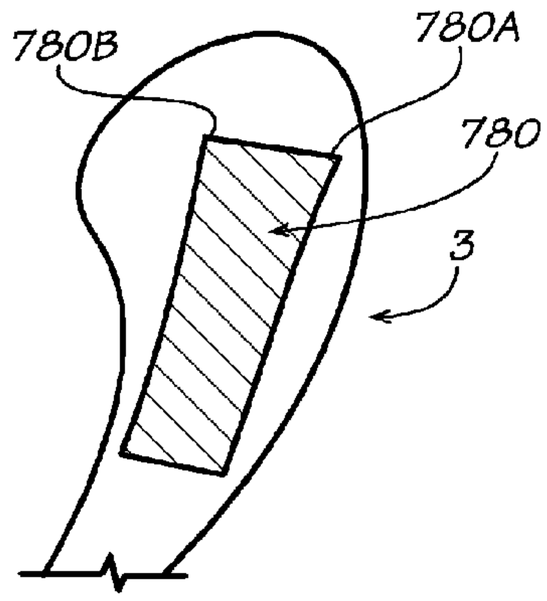

FIG. 22A

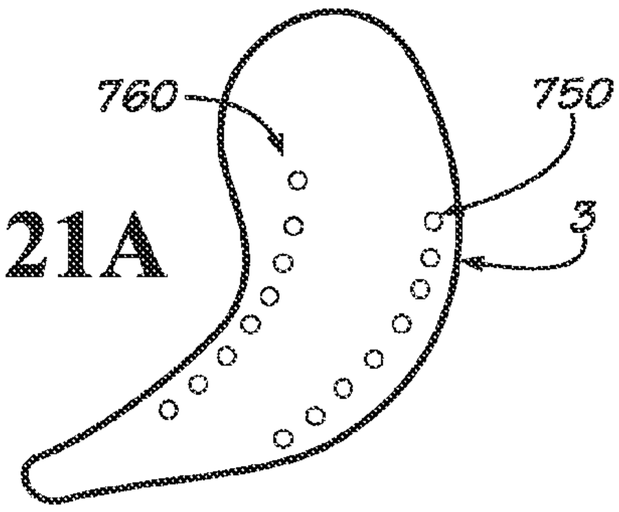

FIG. 21A

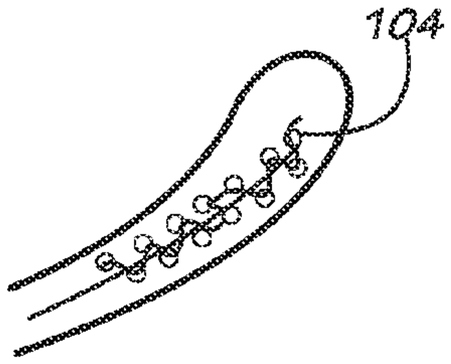

FIG. 21B

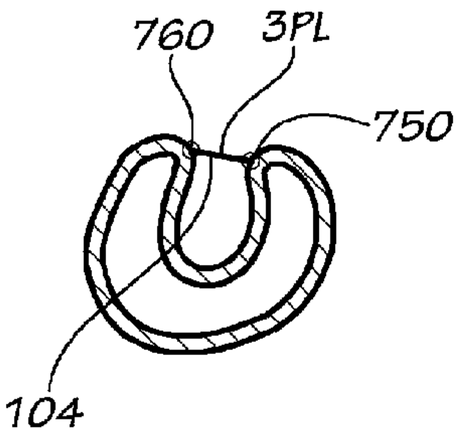

FIG. 21C

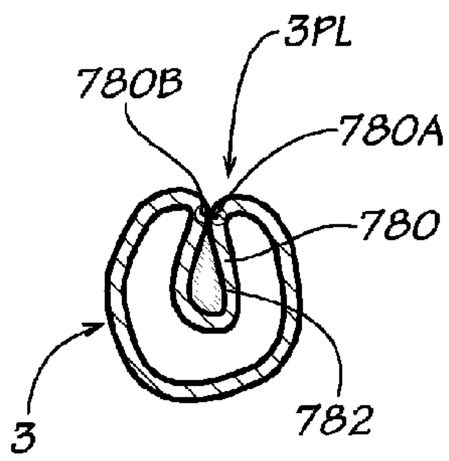

FIG. 22B

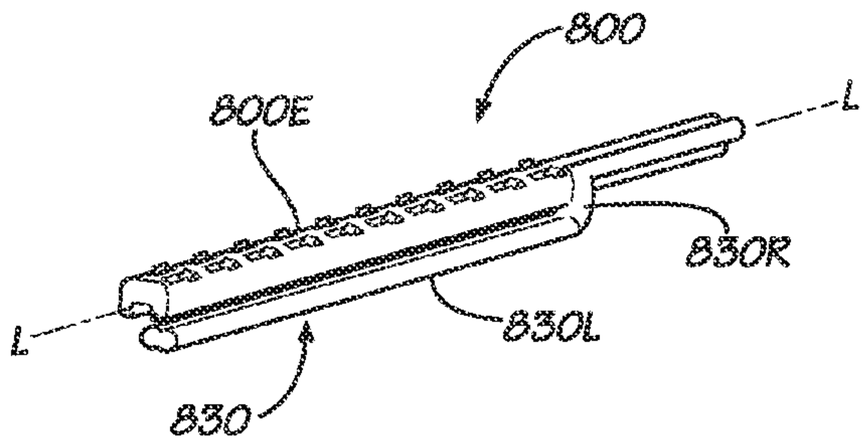

FIG. 23A

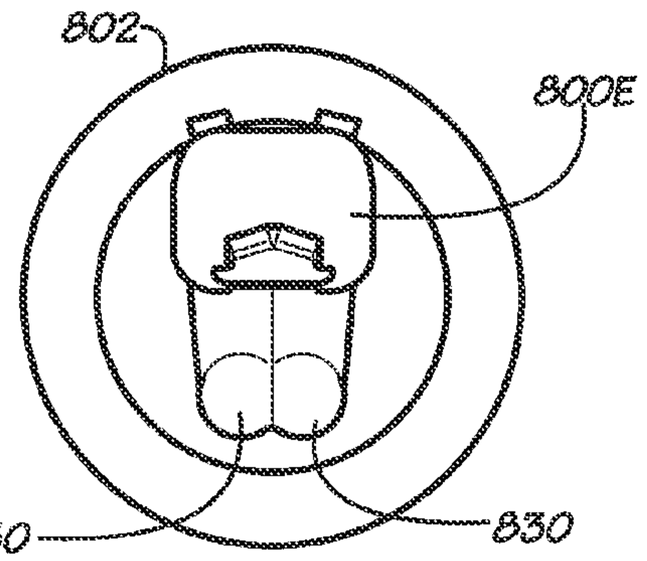

FIG. 23B

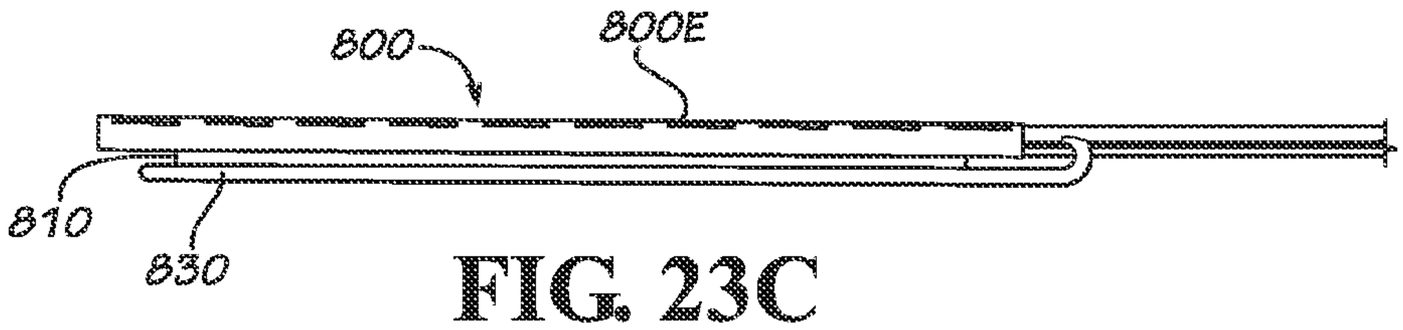

FIG. 23C

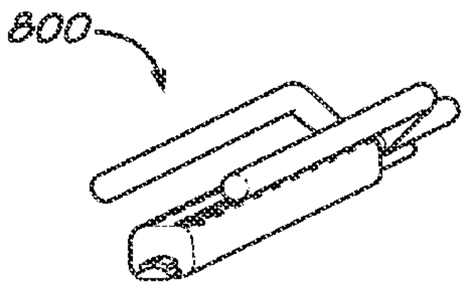

FIG. 23D

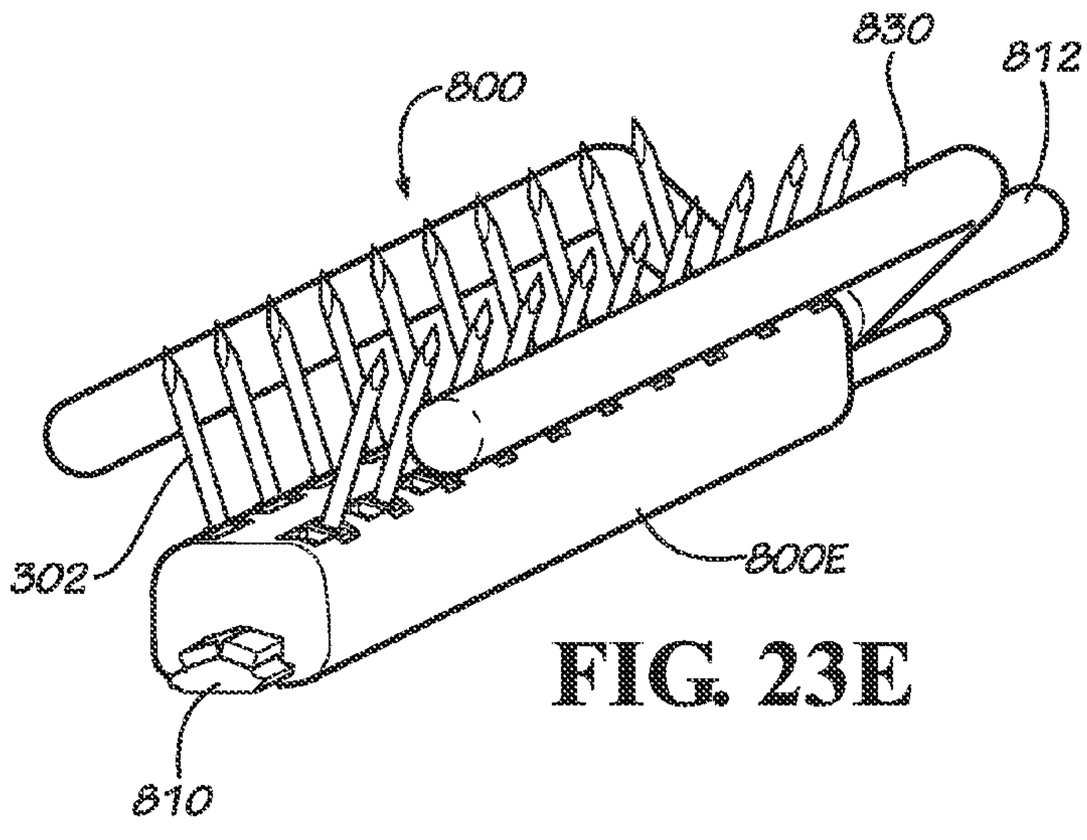

FIG. 23E

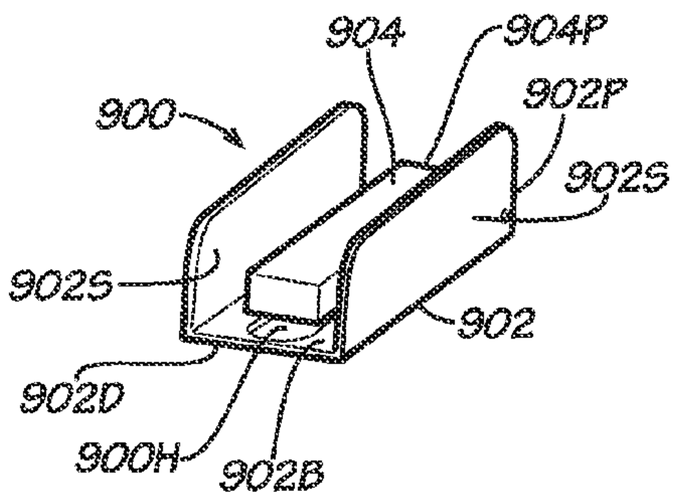

FIG. 24A

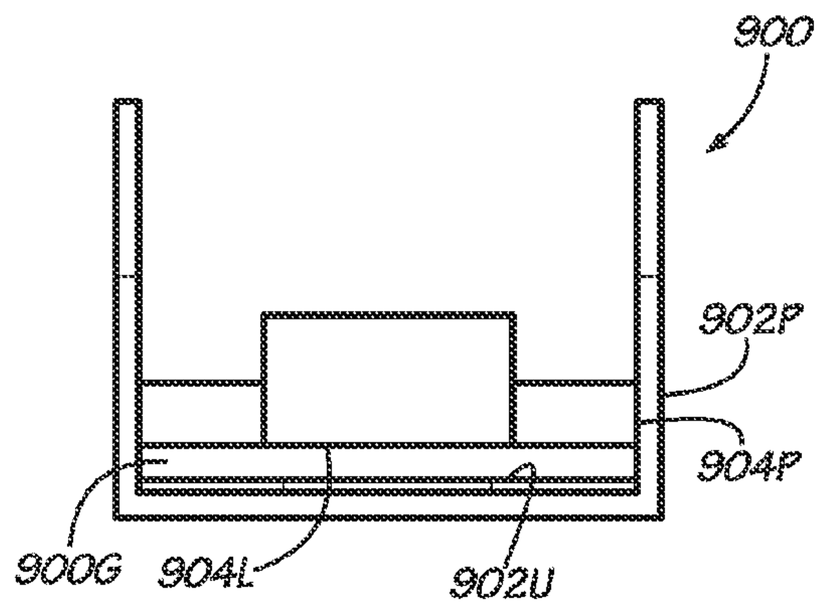

FIG. 24B

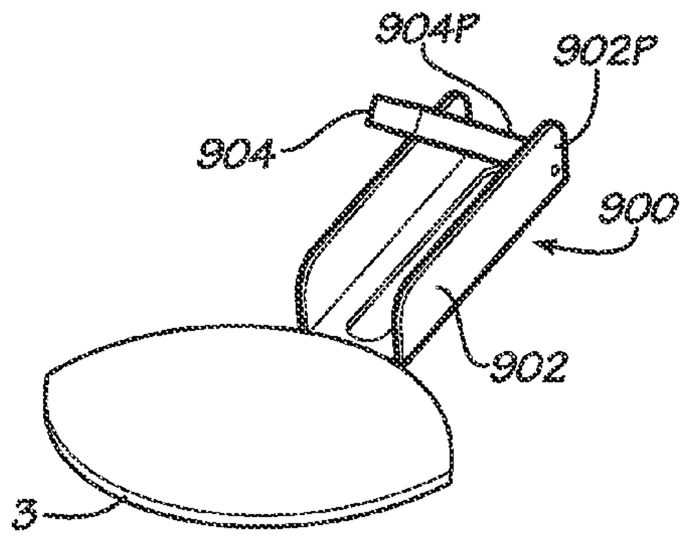

FIG. 24C

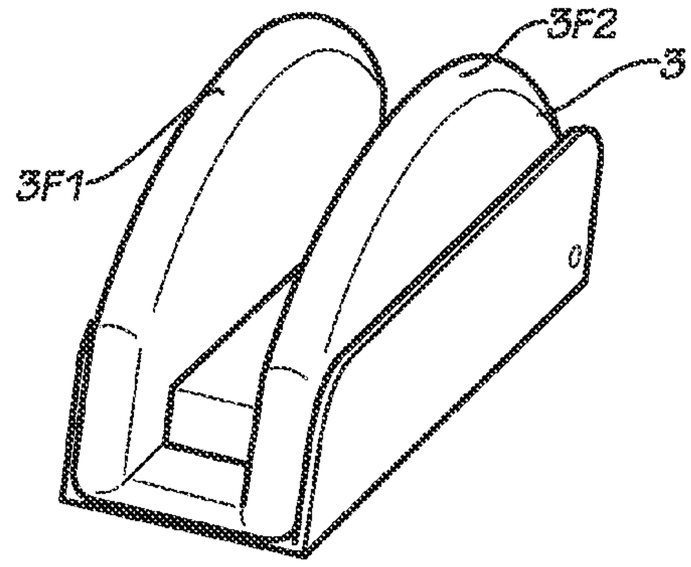

FIG. 24D

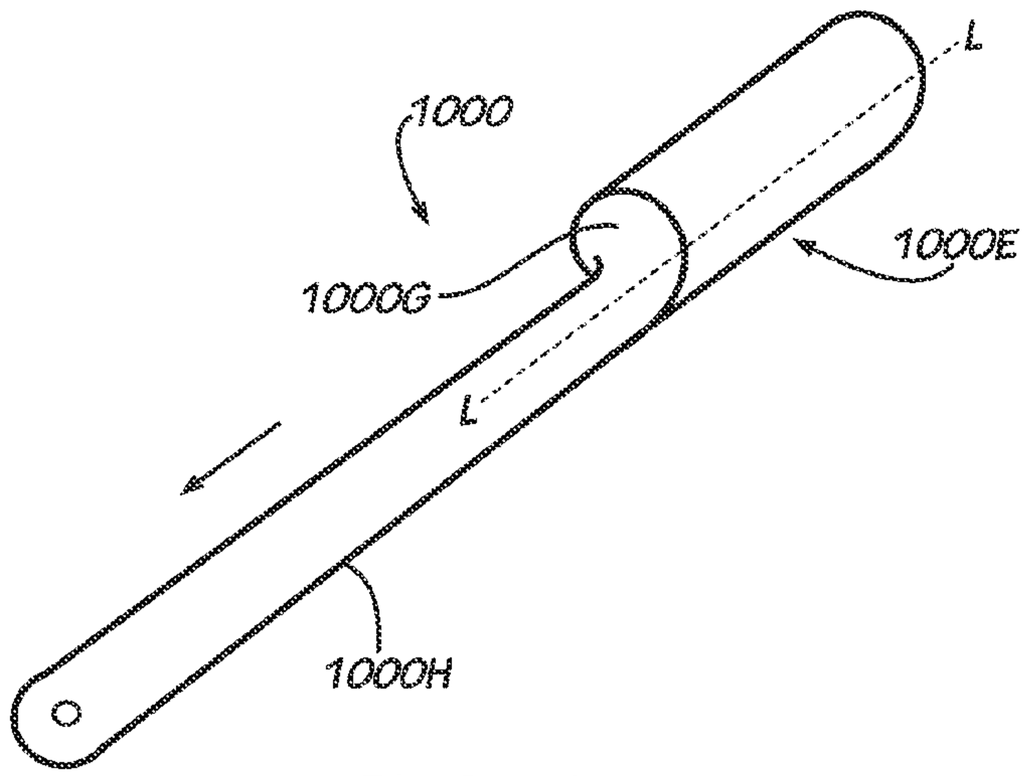

FIG. 25A

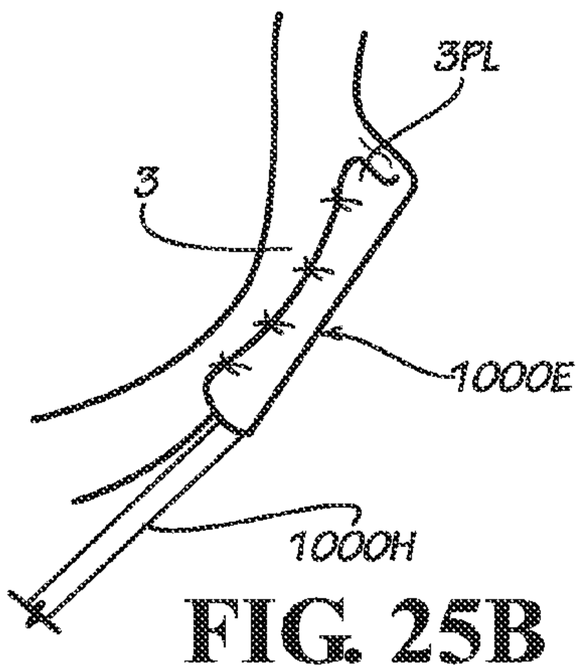

FIG. 25B

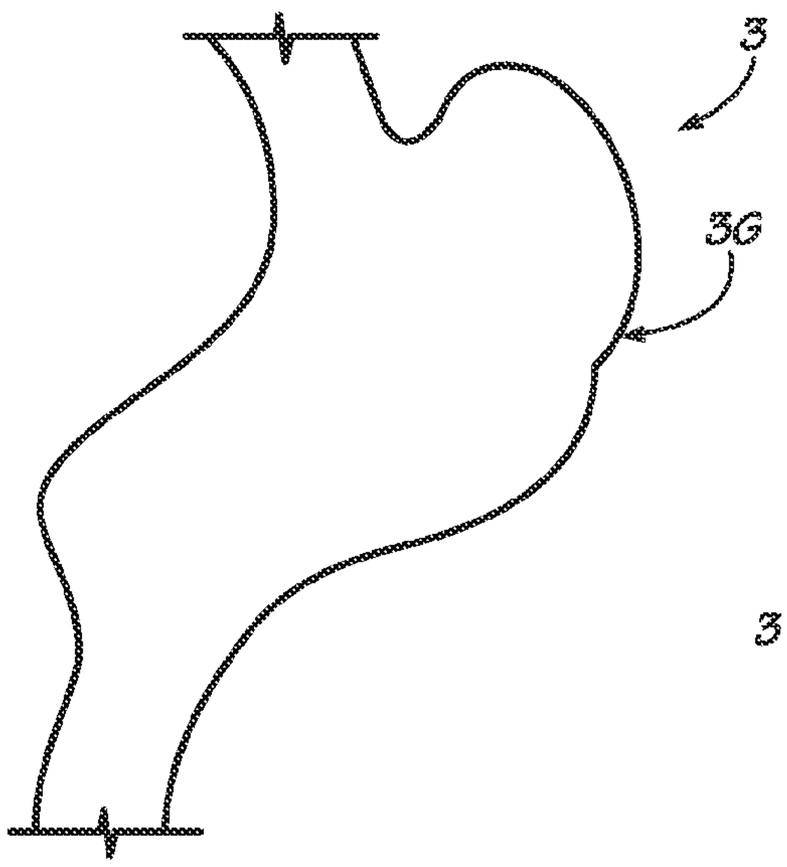

FIG. 26A

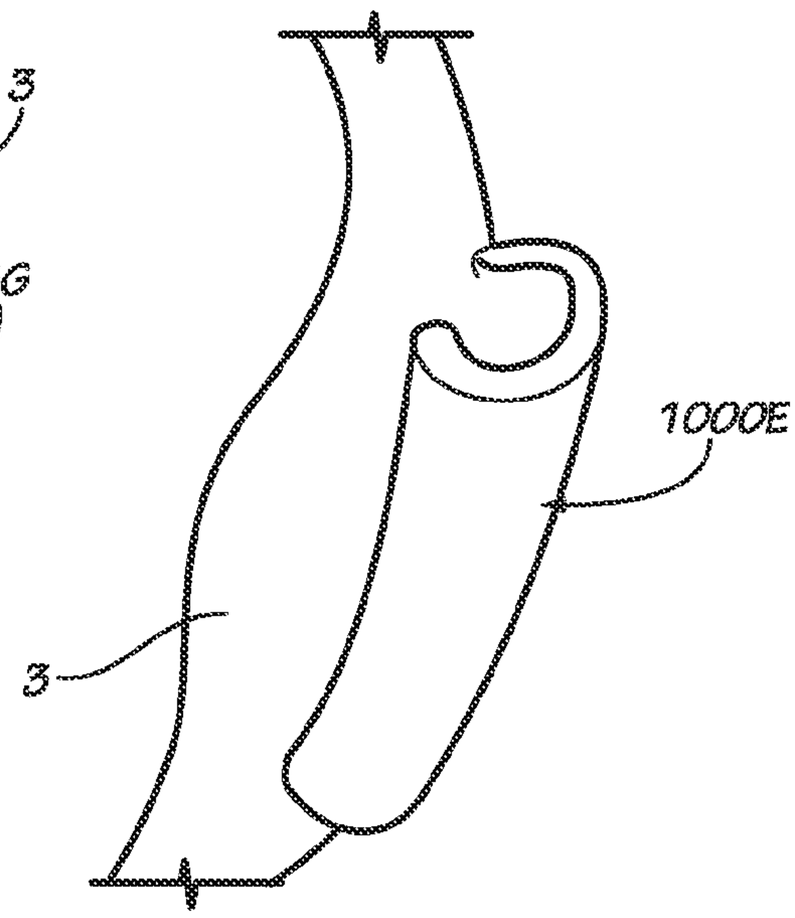

FIG. 26B

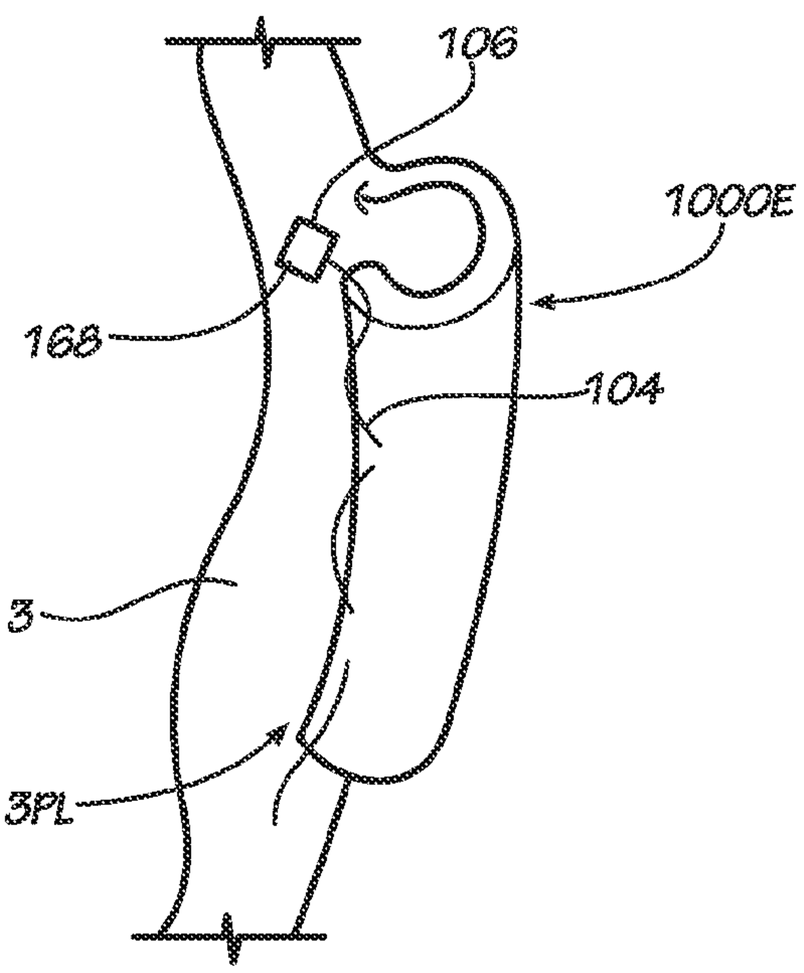

FIG. 26C

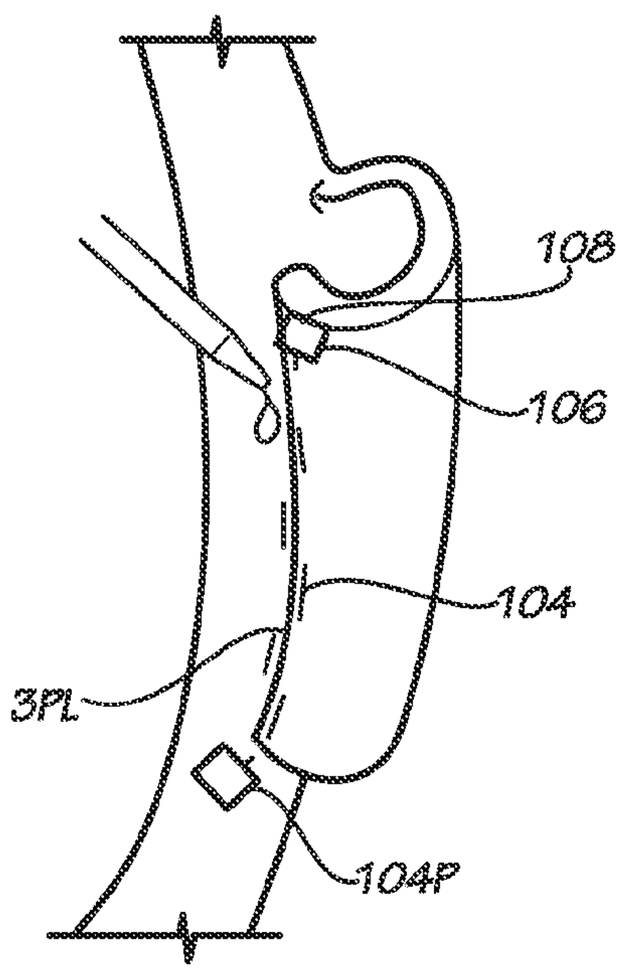

FIG. 26D

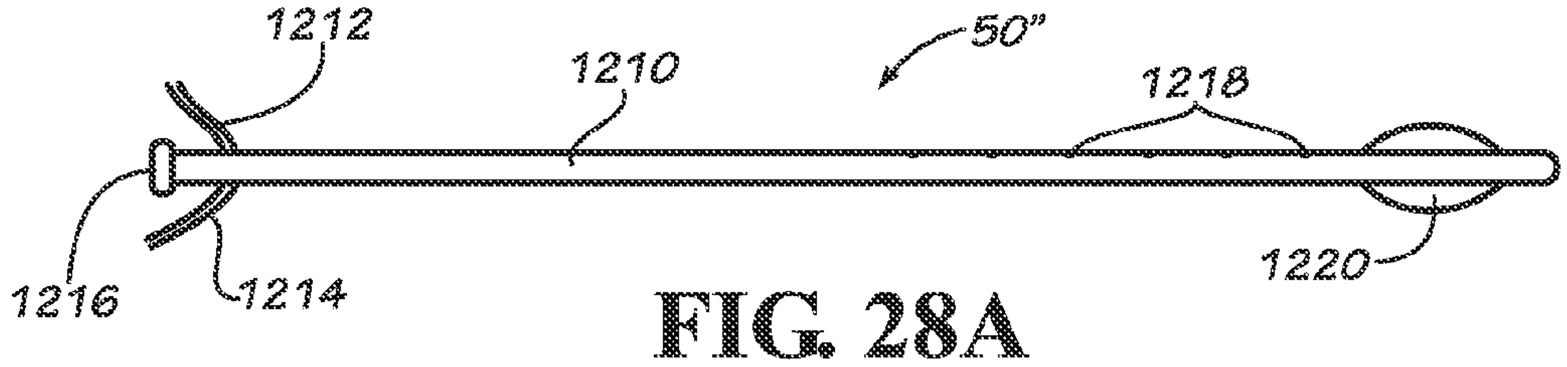

FIG. 28A

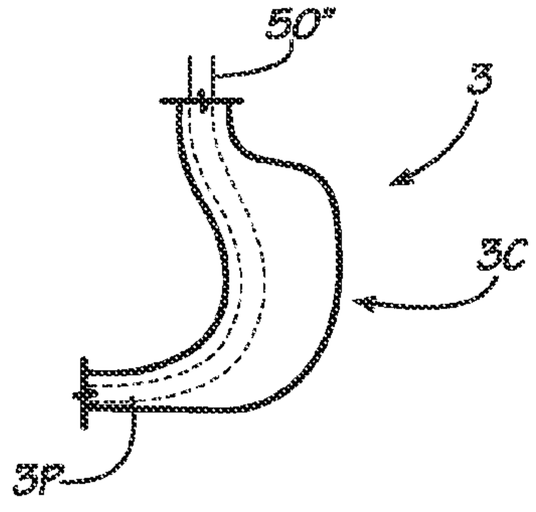

FIG. 28B

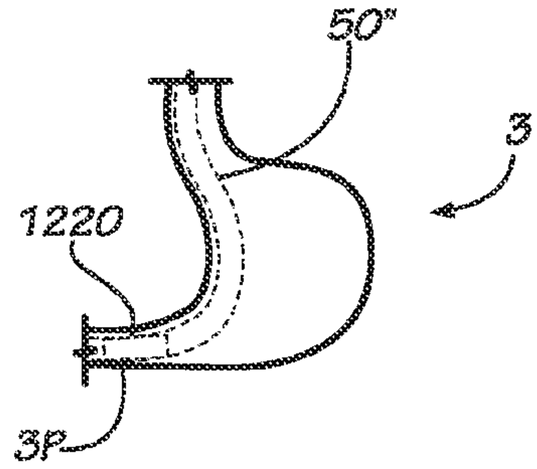

FIG. 28C

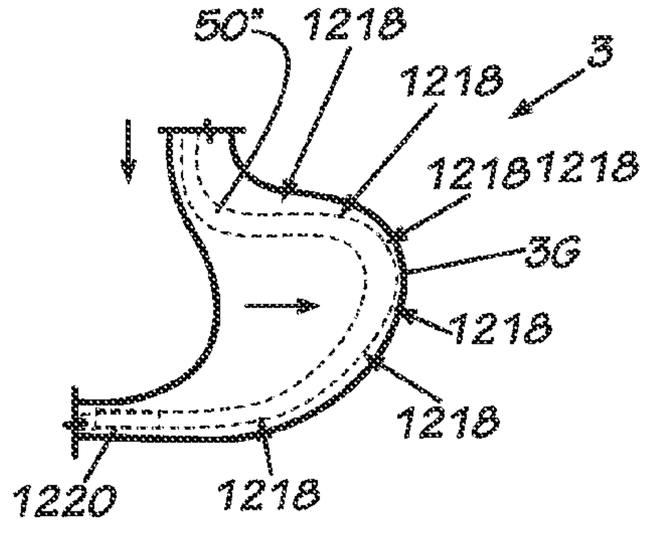

FIG. 28D

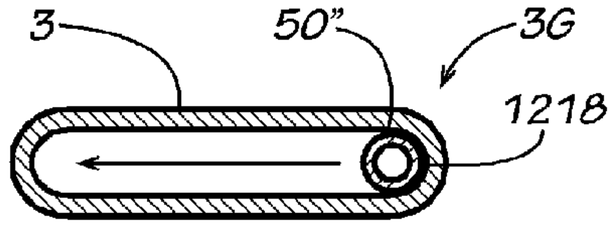

FIG. 28E

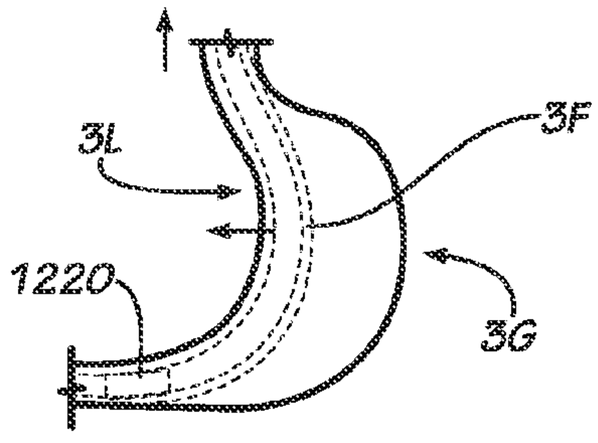

FIG. 28F

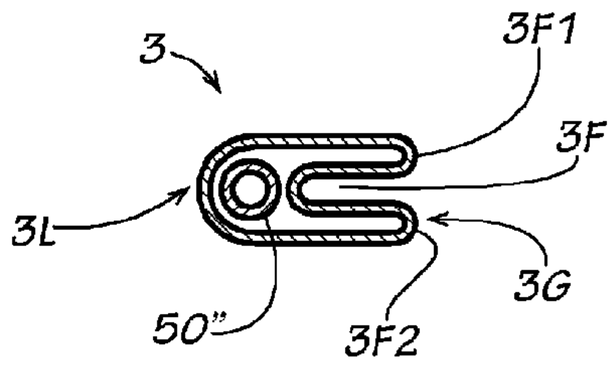

FIG. 28G

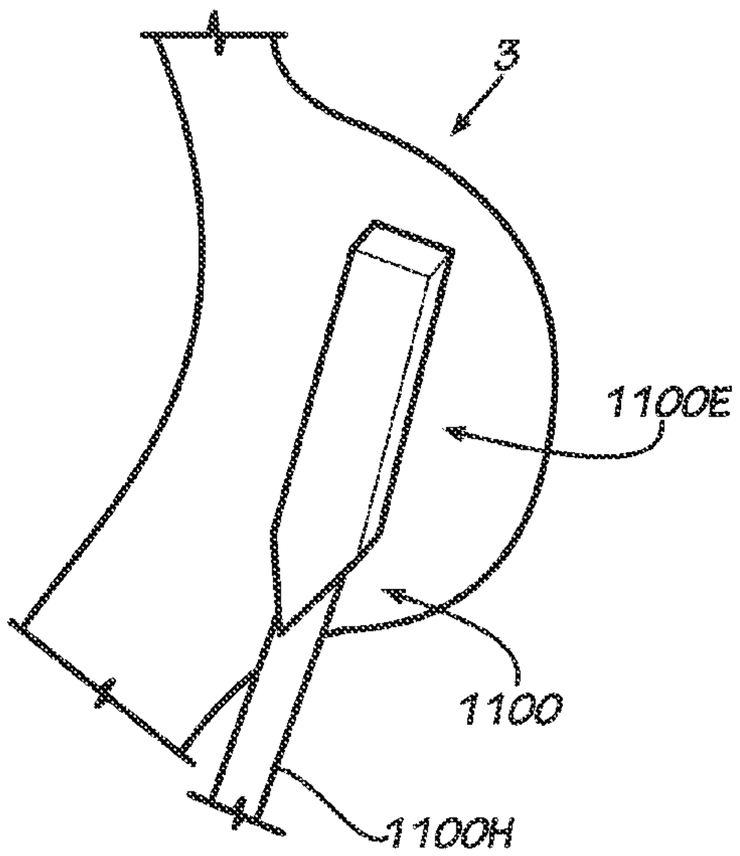

FIG. 27A

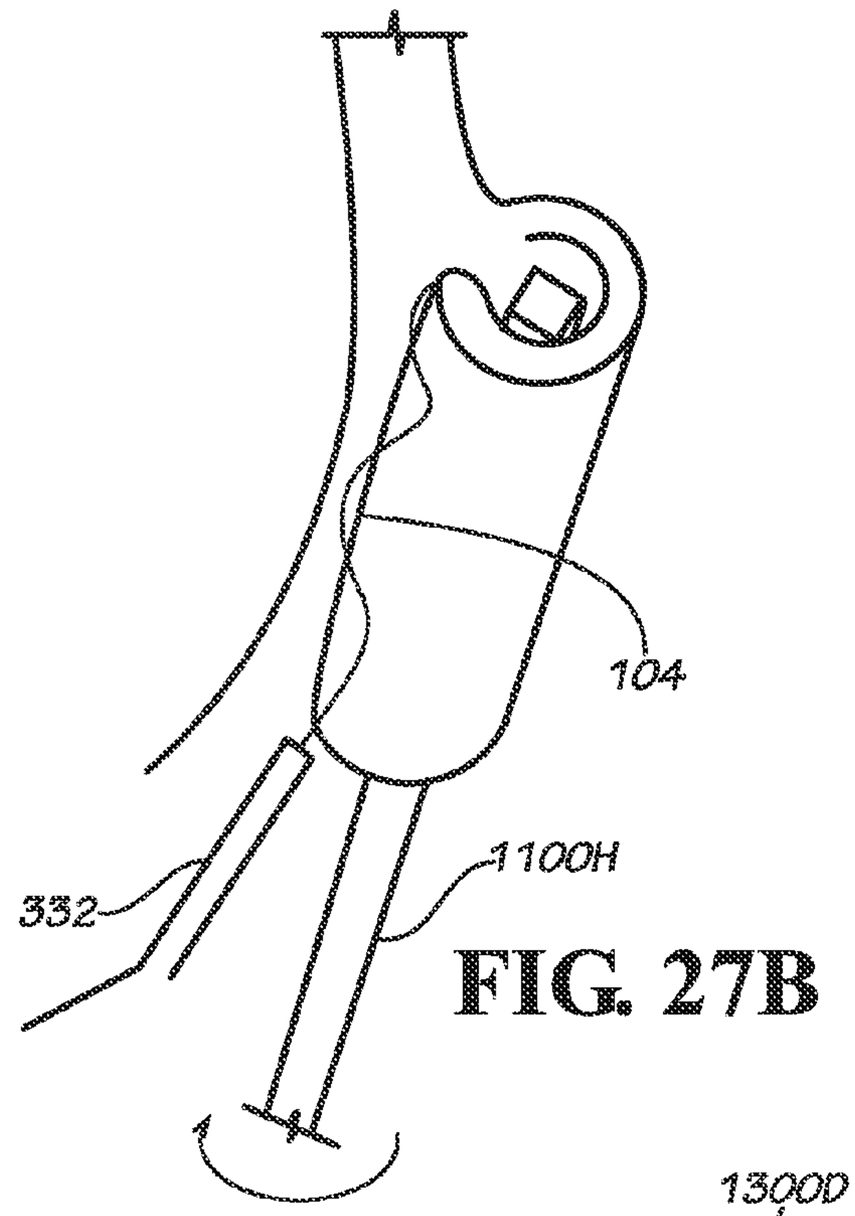

FIG. 27B

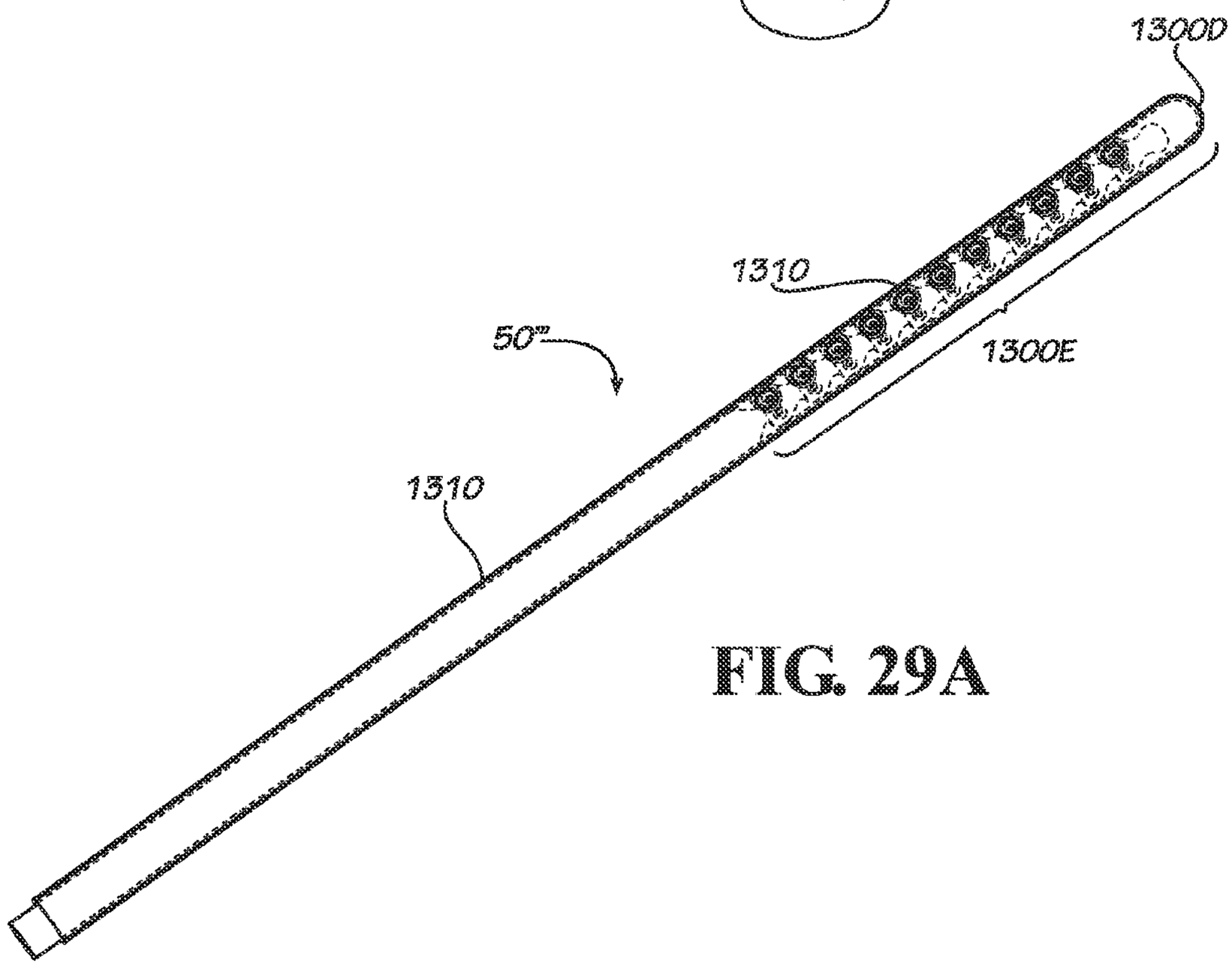

FIG. 29A

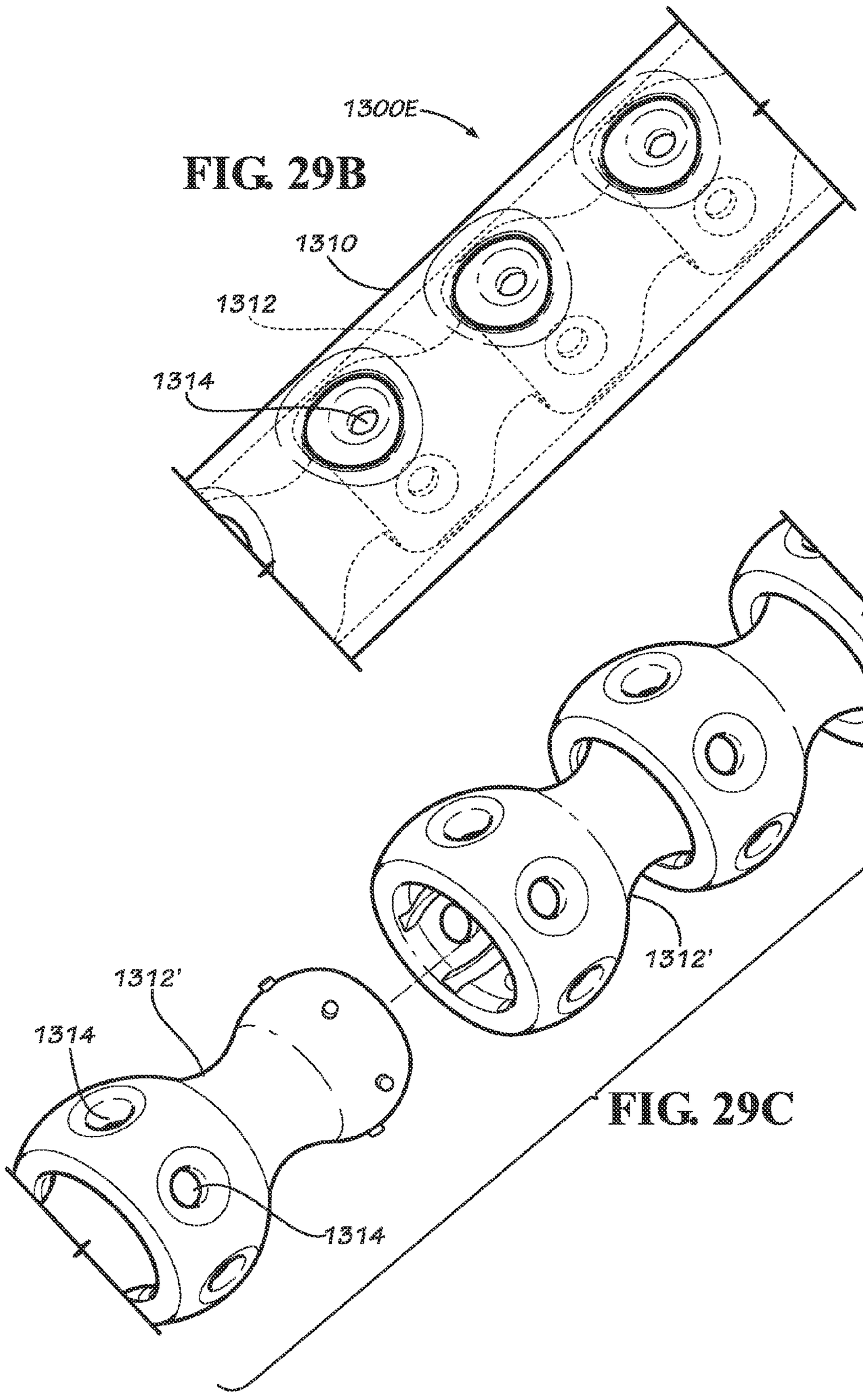

FIG. 29B

FIG. 29C

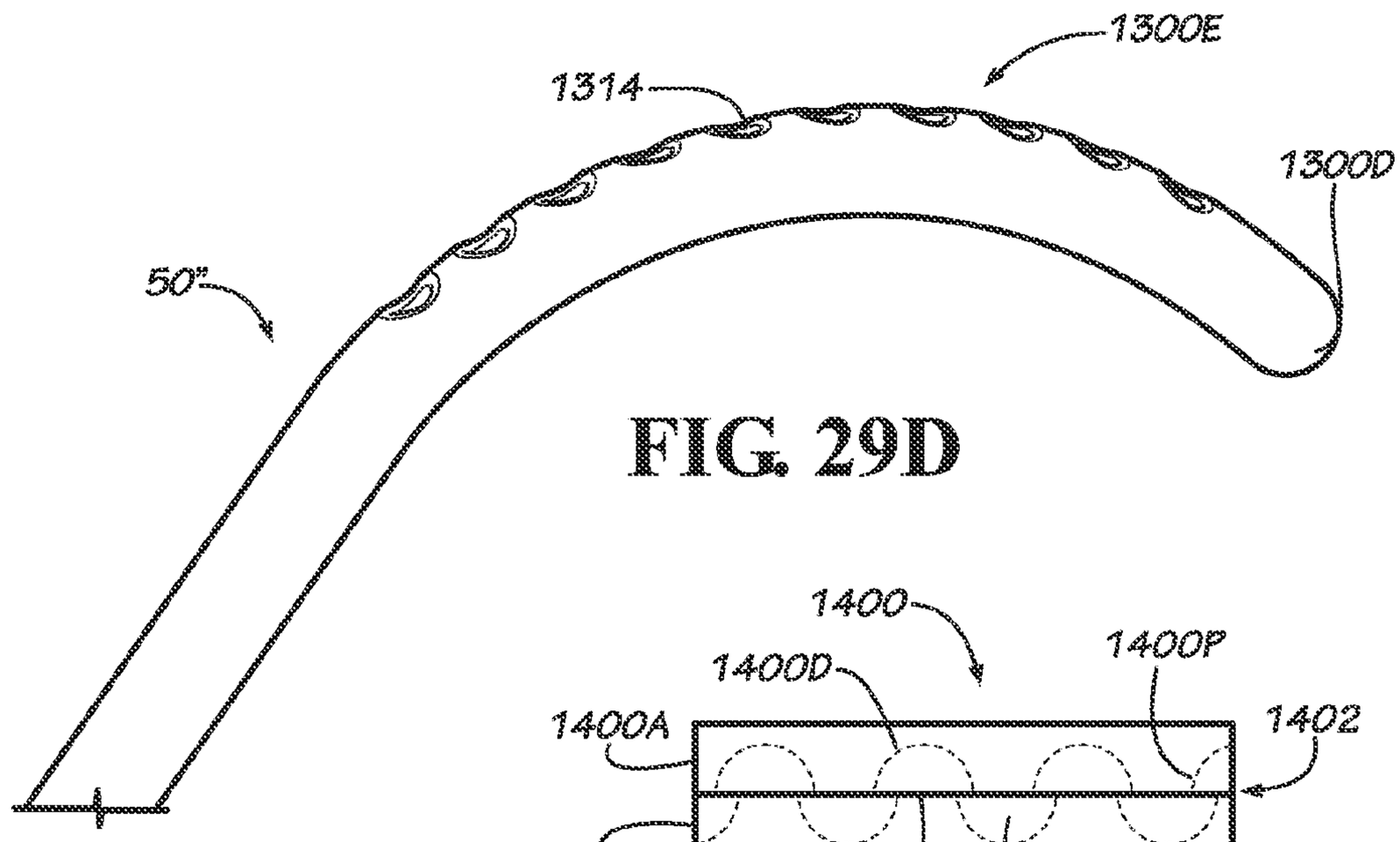

FIG. 29D

FIG. 30A

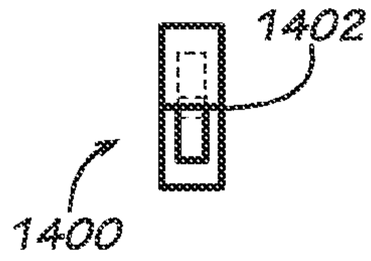

FIG. 30B

FIG. 30C

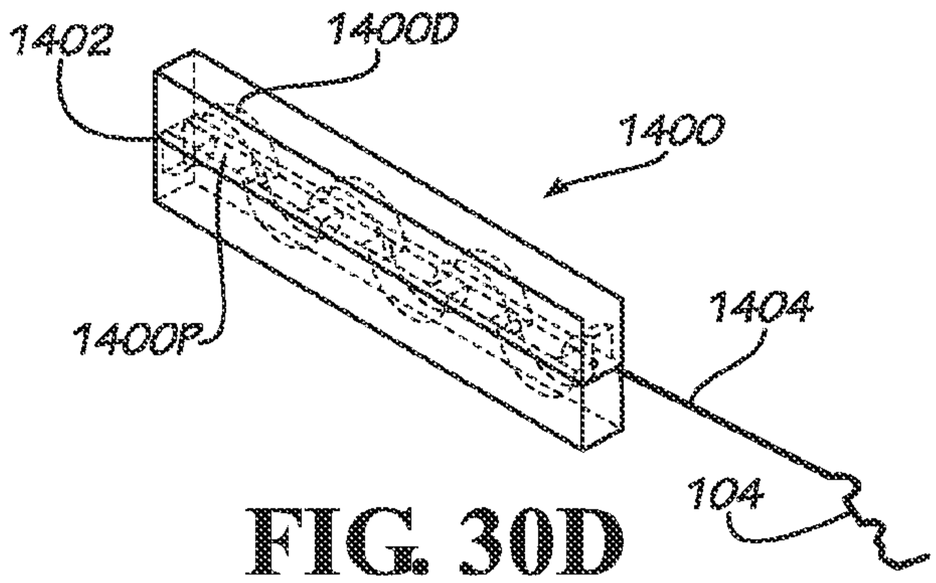

FIG. 30D

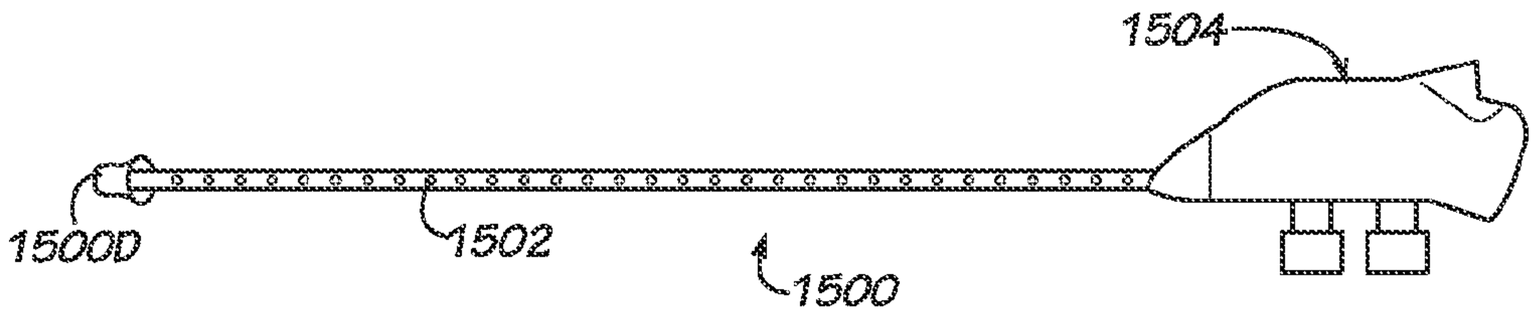

FIG. 31A

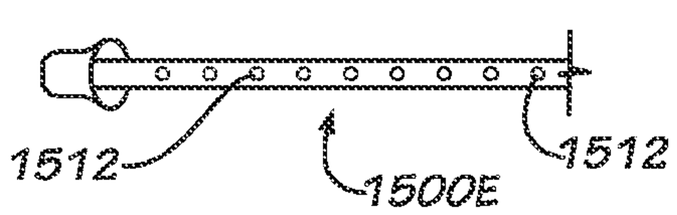

FIG. 31B

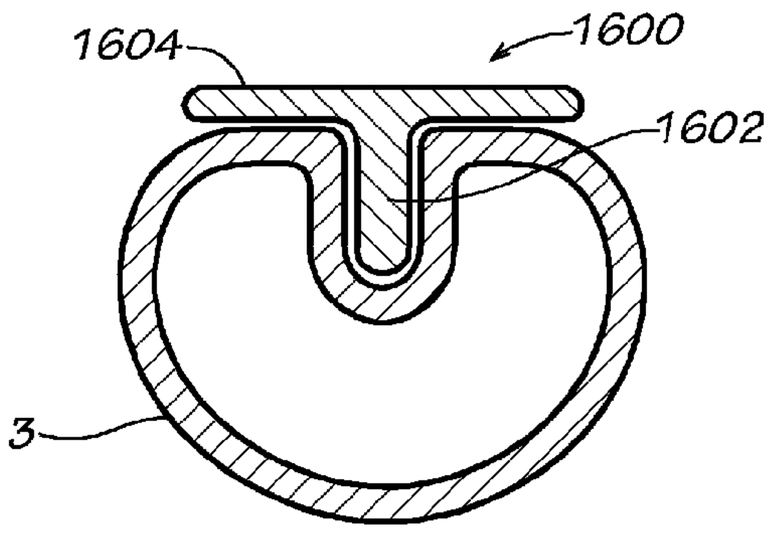

FIG. 32A

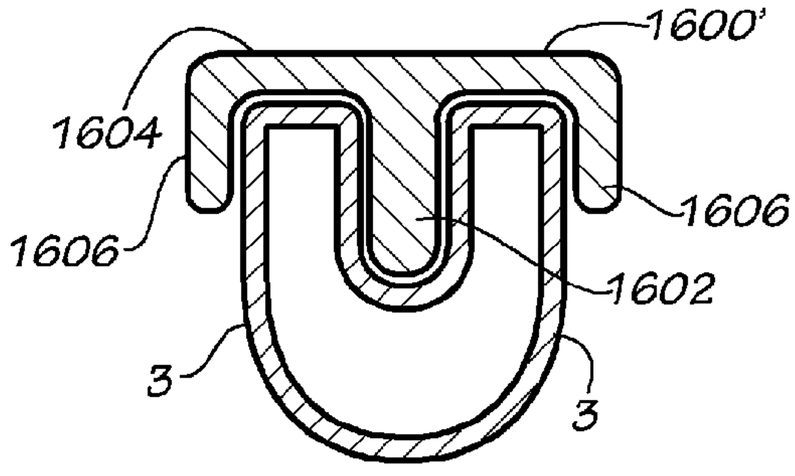

FIG. 32B

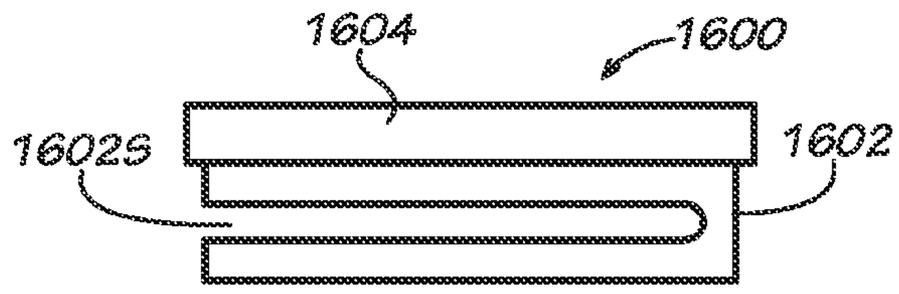

FIG. 32C

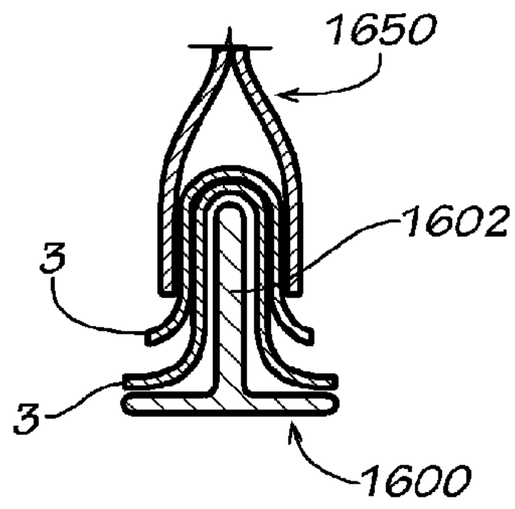

FIG. 33

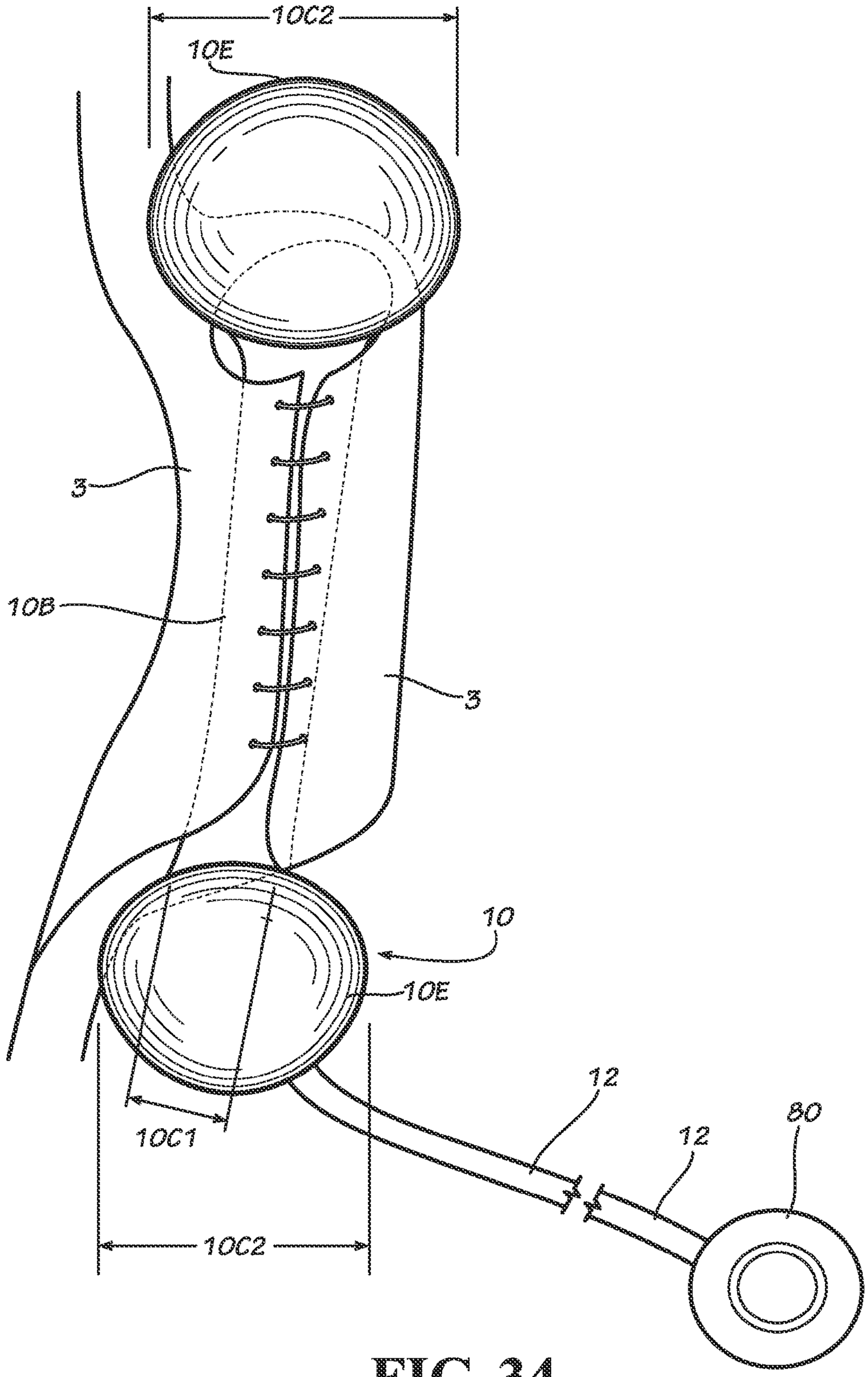

FIG. 34

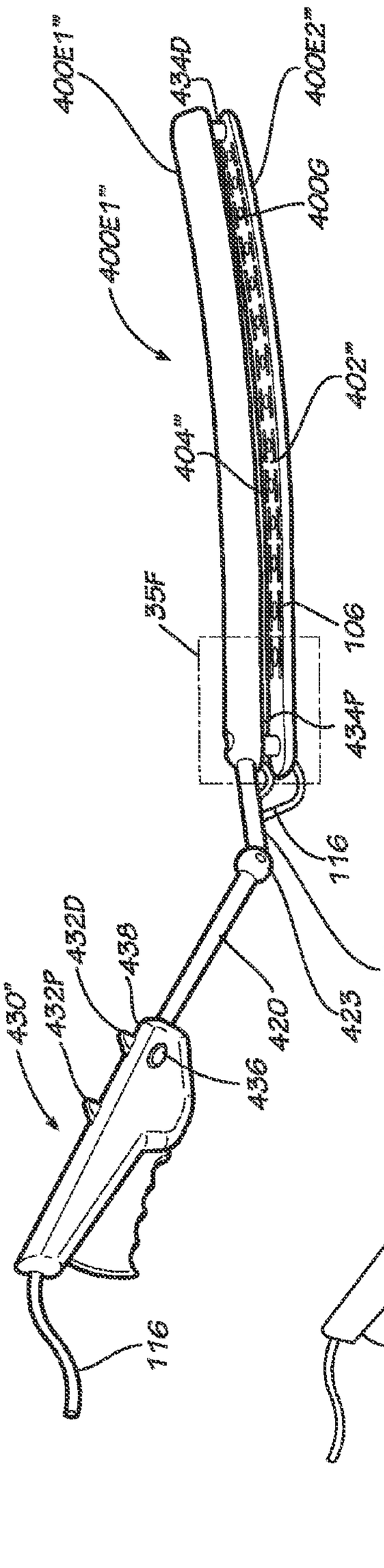

FIG. 35A

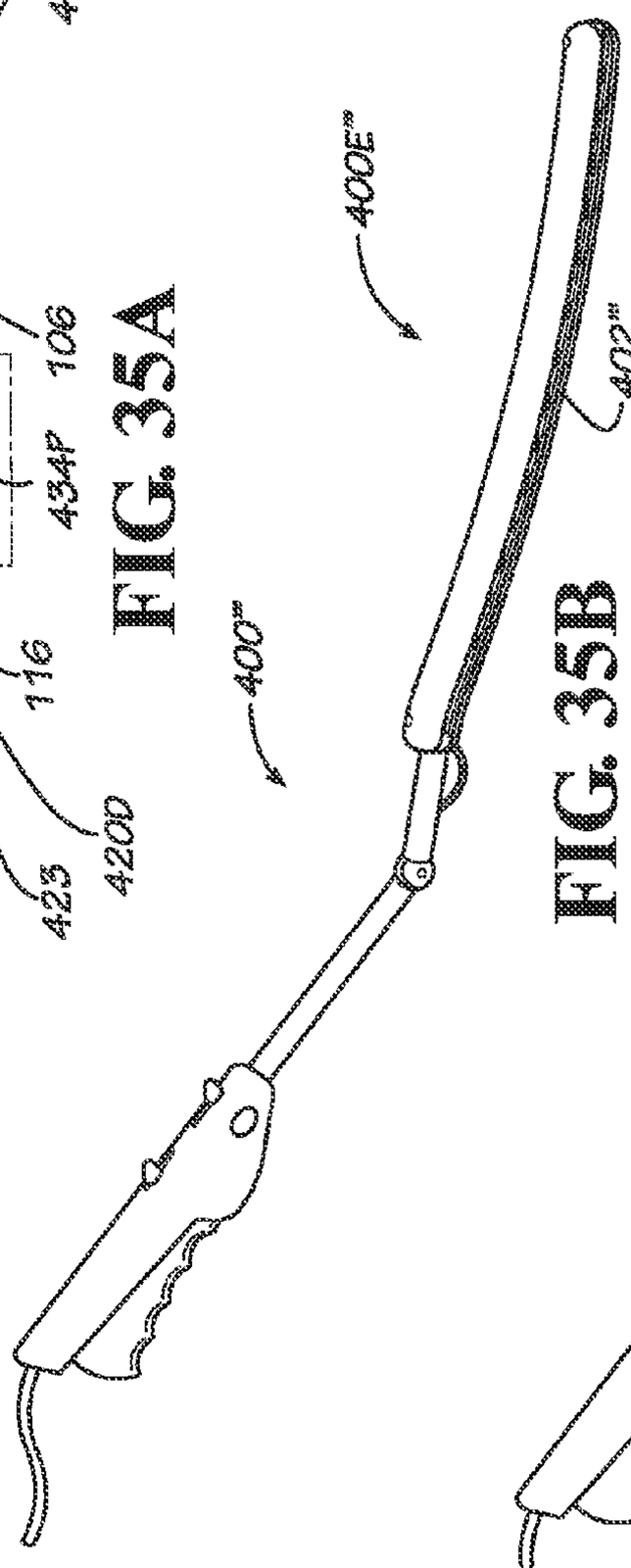

FIG. 35B

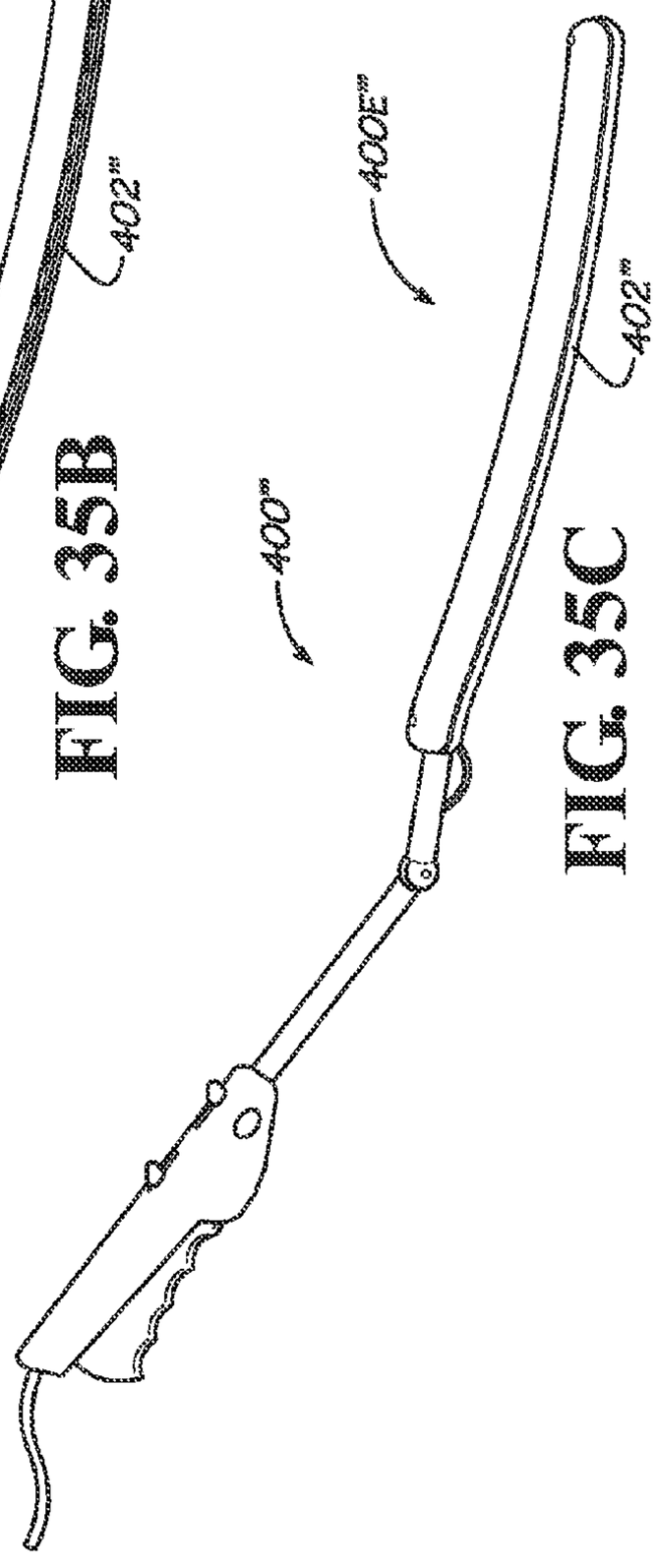

FIG. 35C

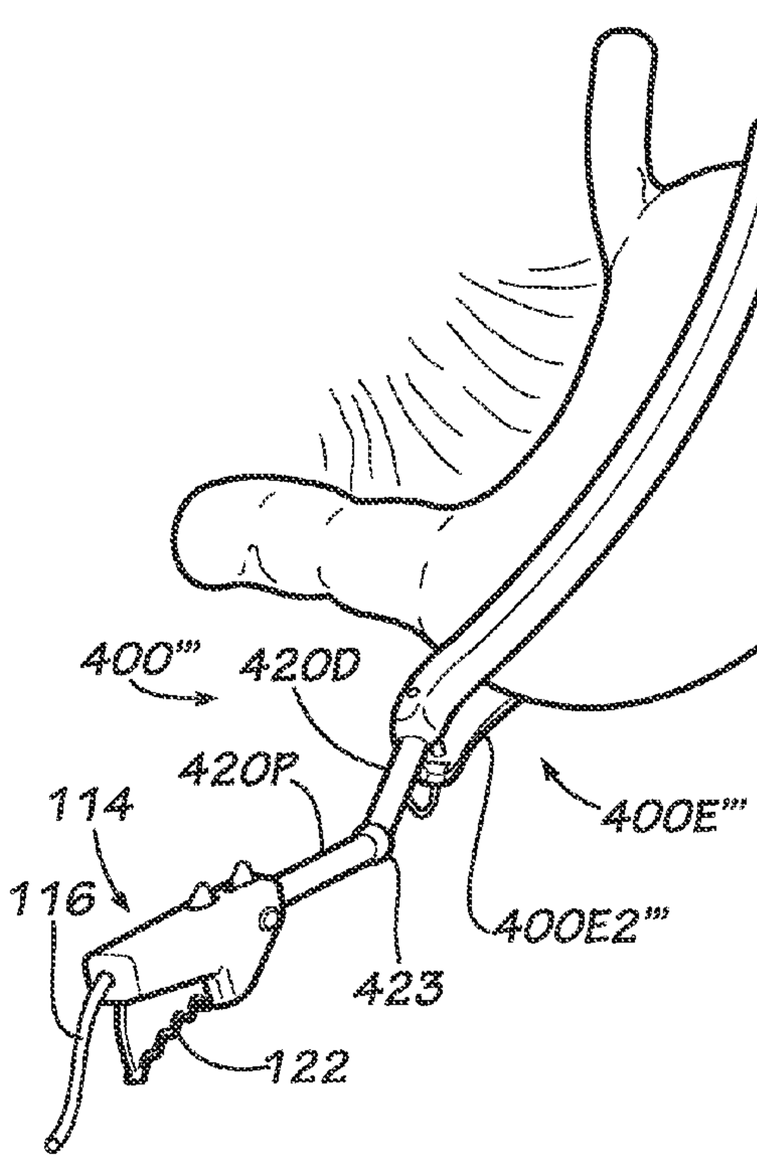

FIG. 35D

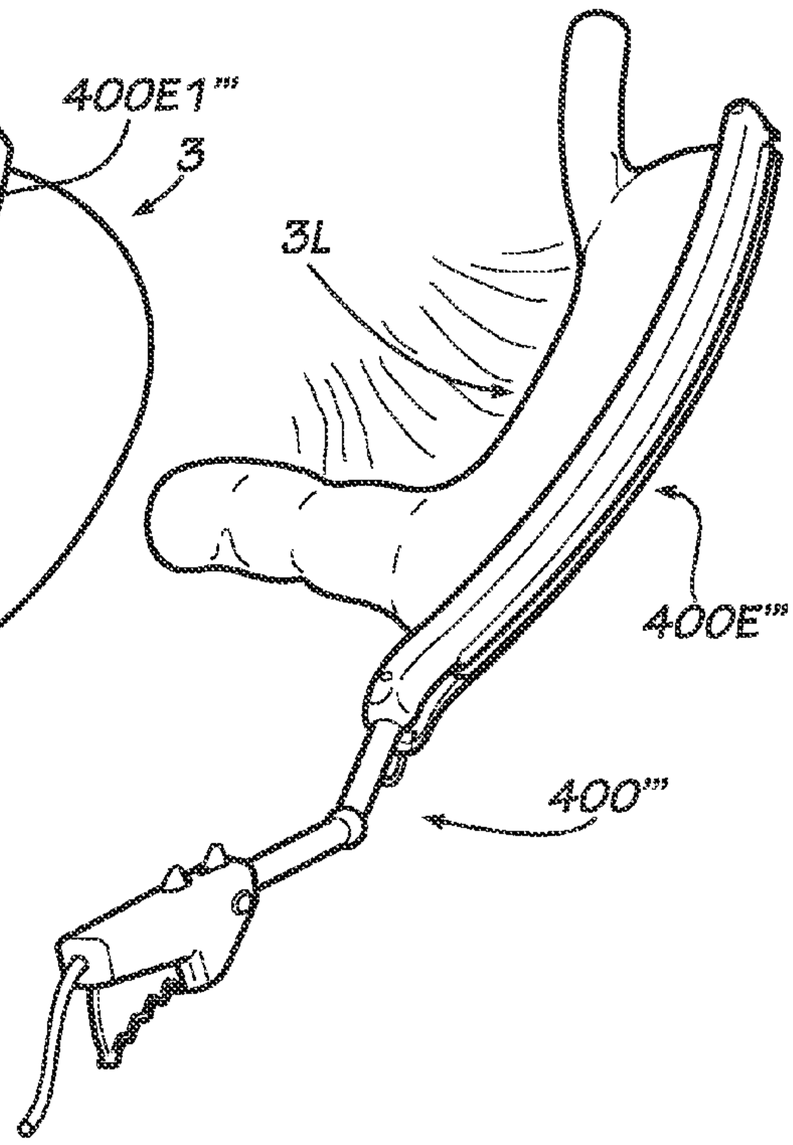

FIG. 35E

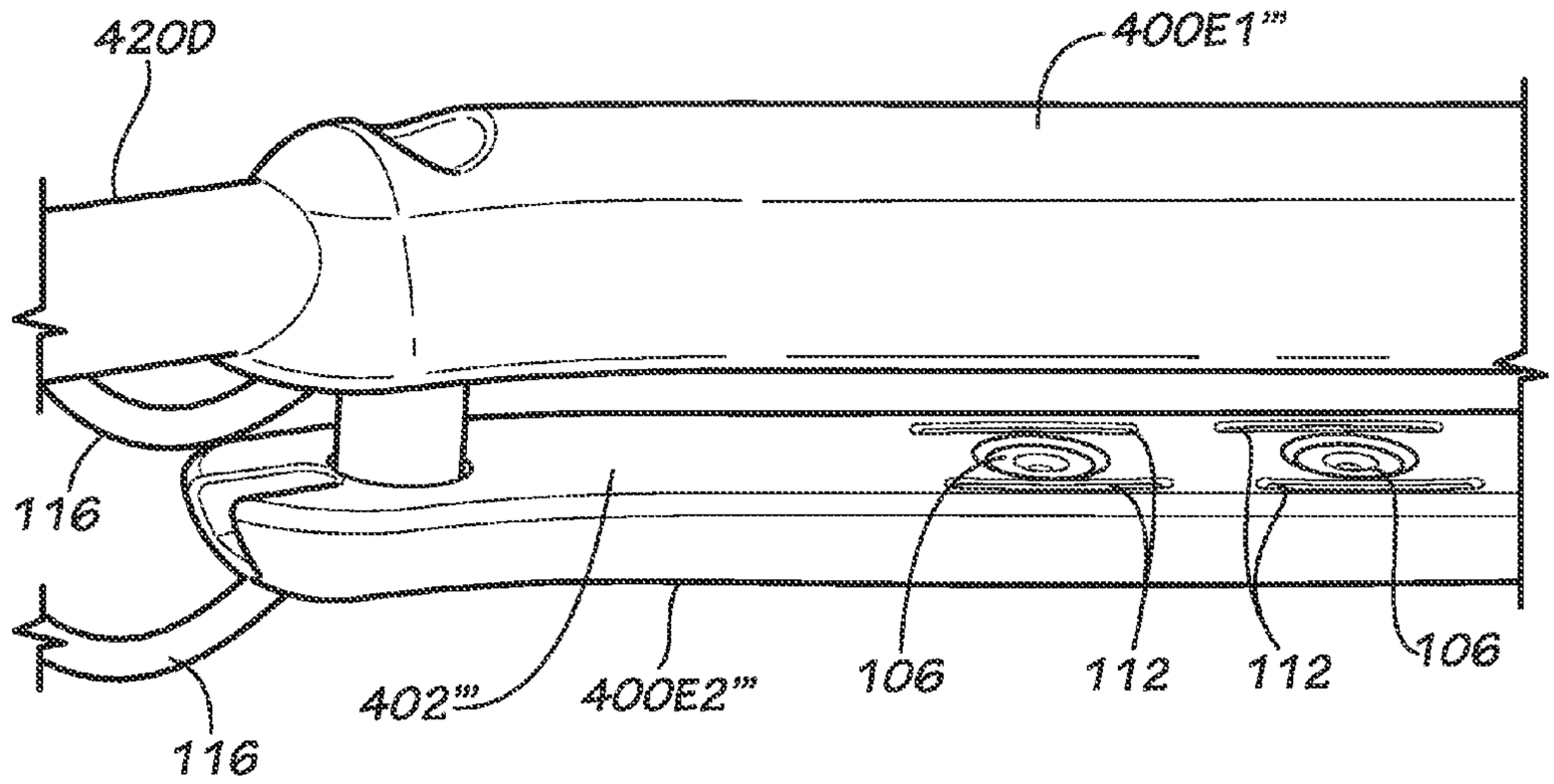

FIG. 35F

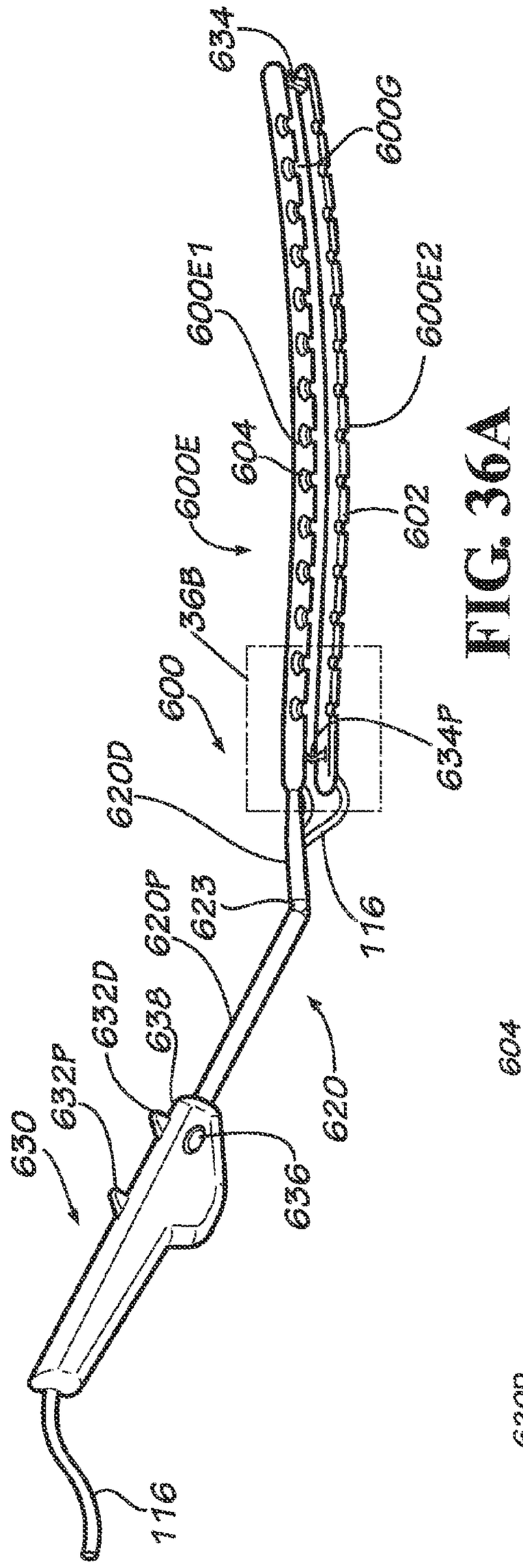

FIG. 36A

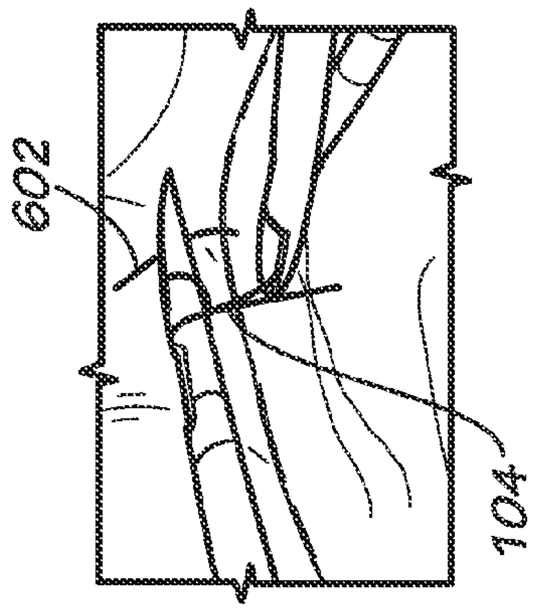

FIG. 36C

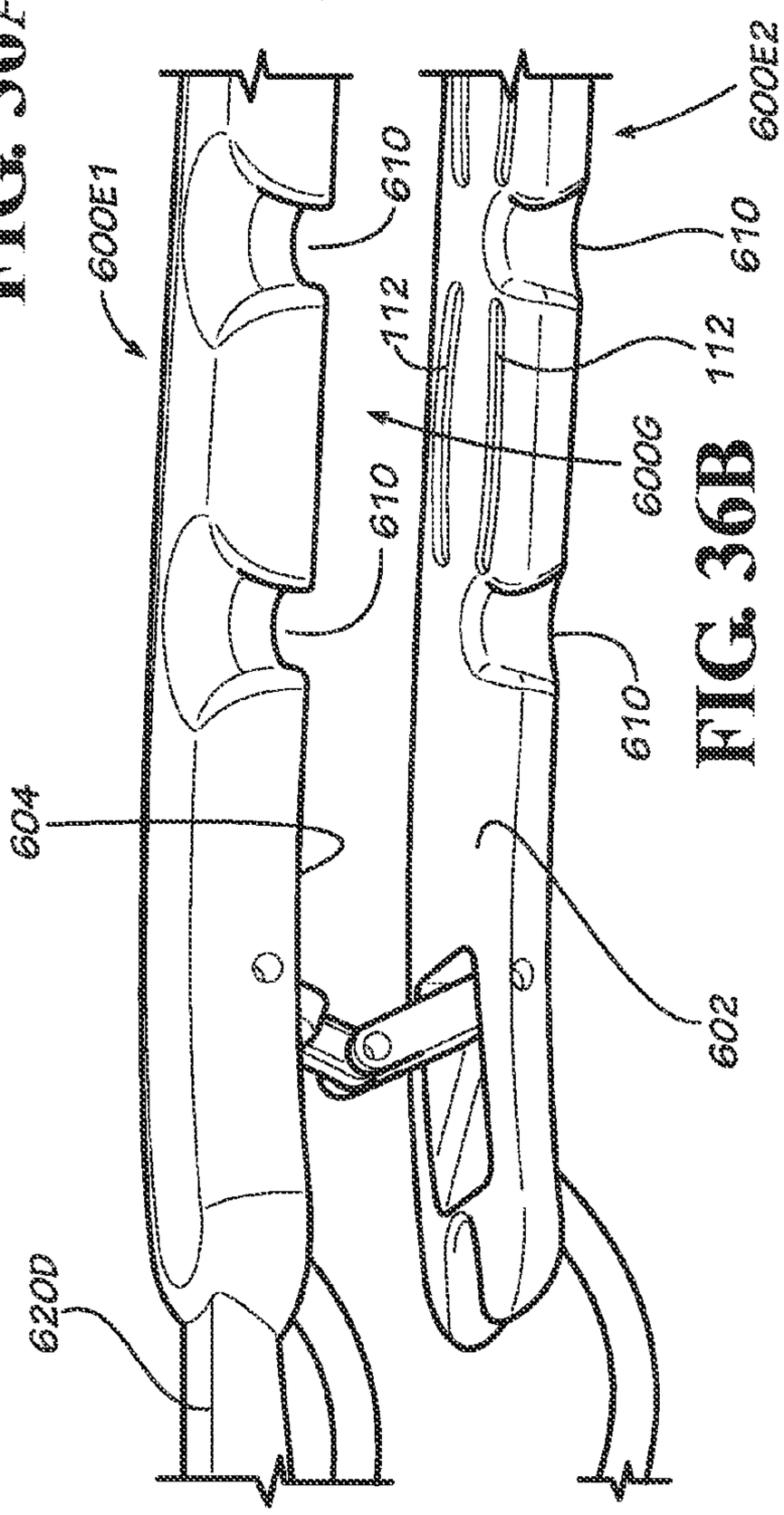

FIG. 36B

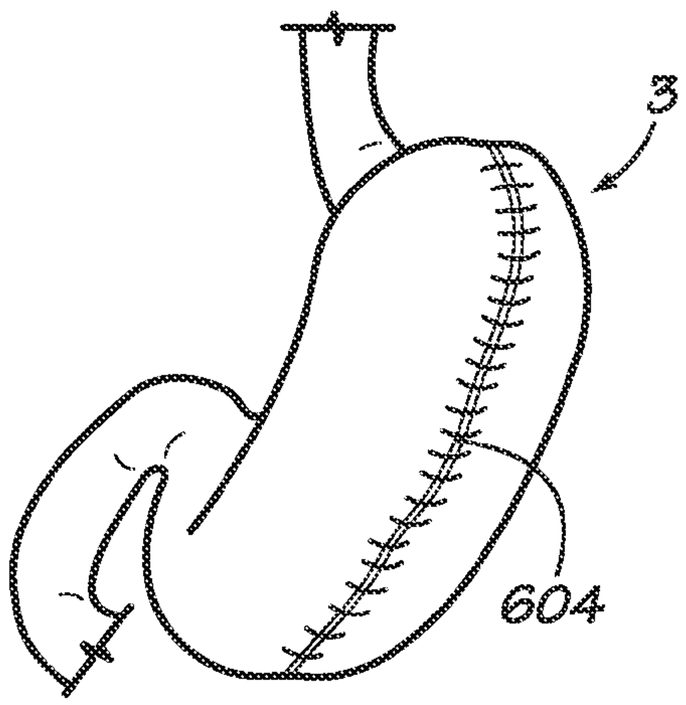

FIG. 36F

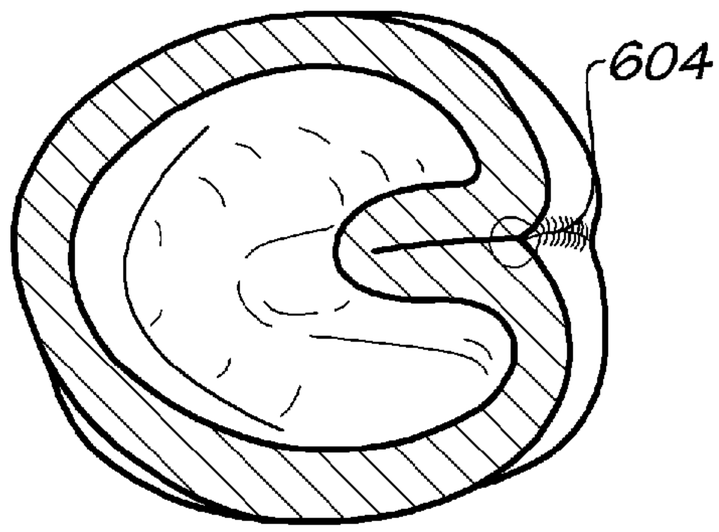

FIG. 36G

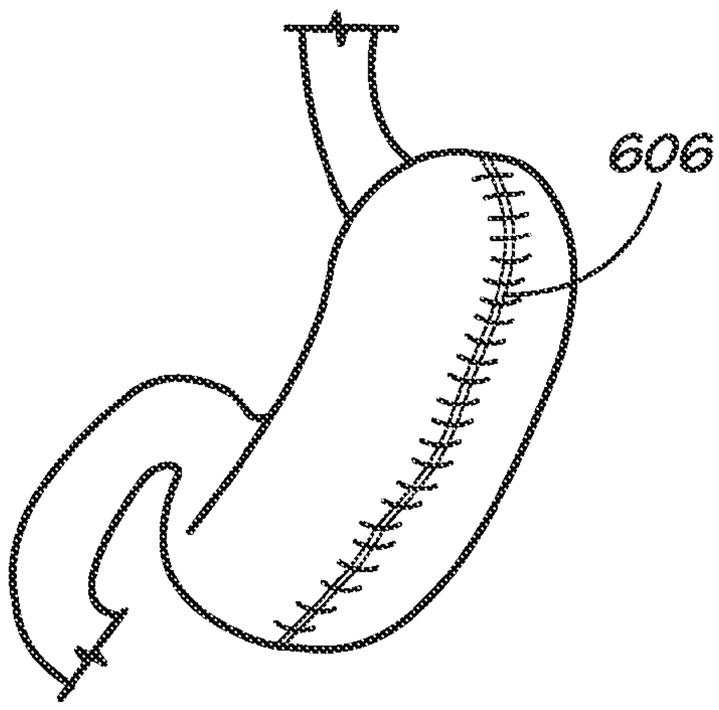

FIG. 36D

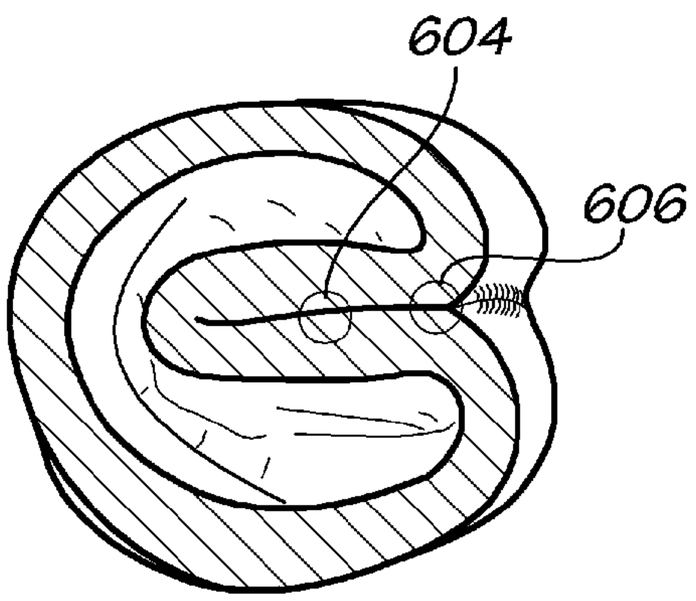

FIG. 36E

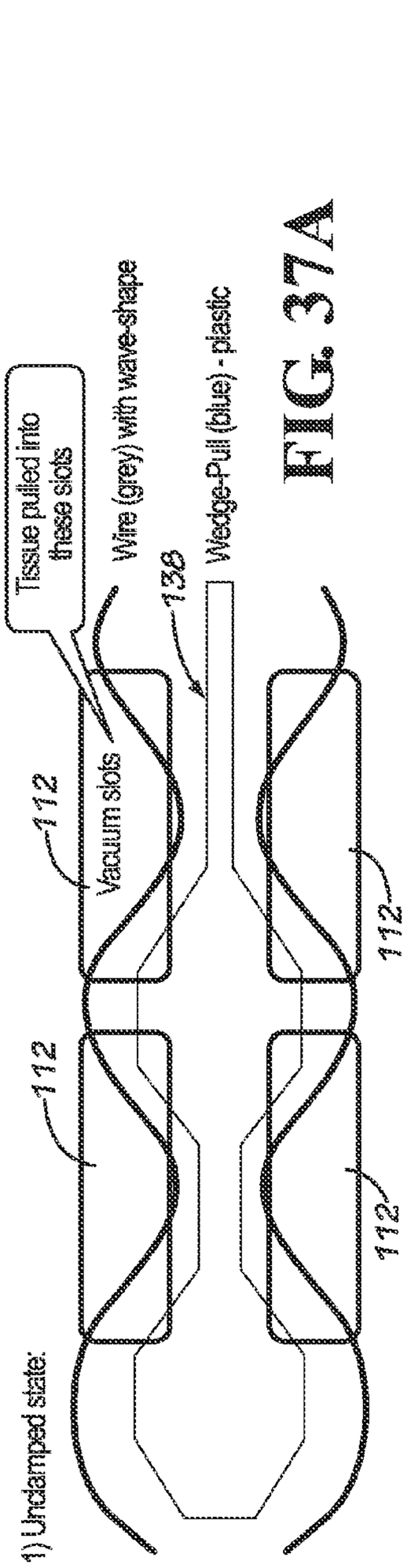

FIG. 37A

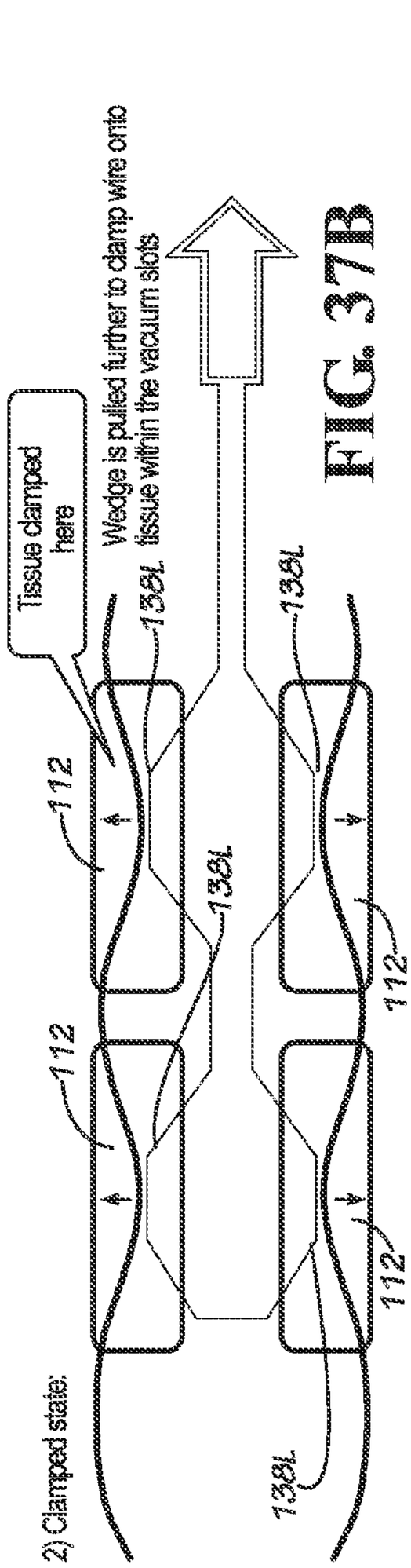

FIG. 37B

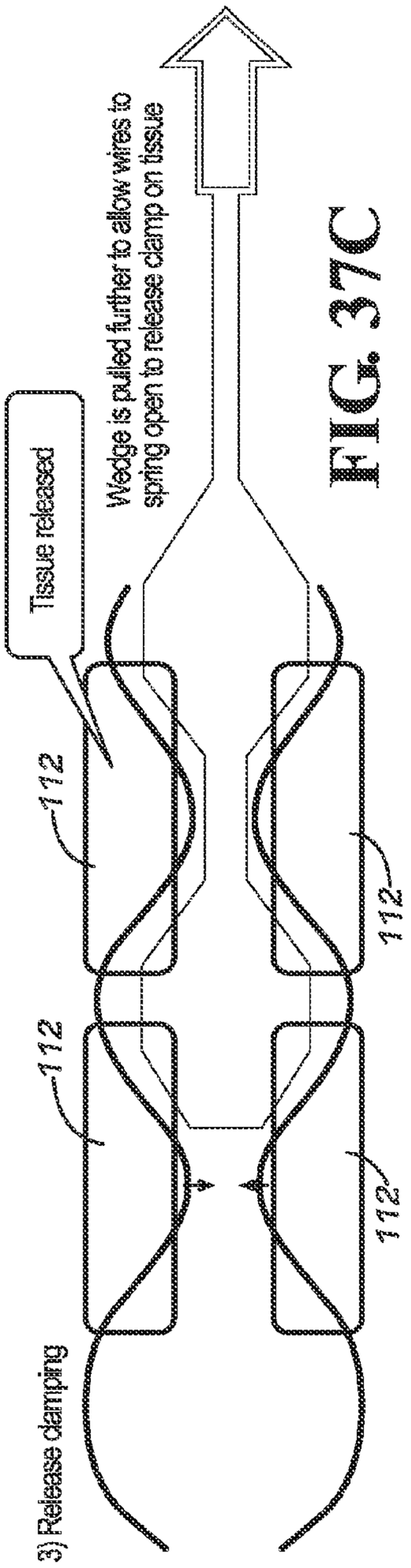

FIG. 37C

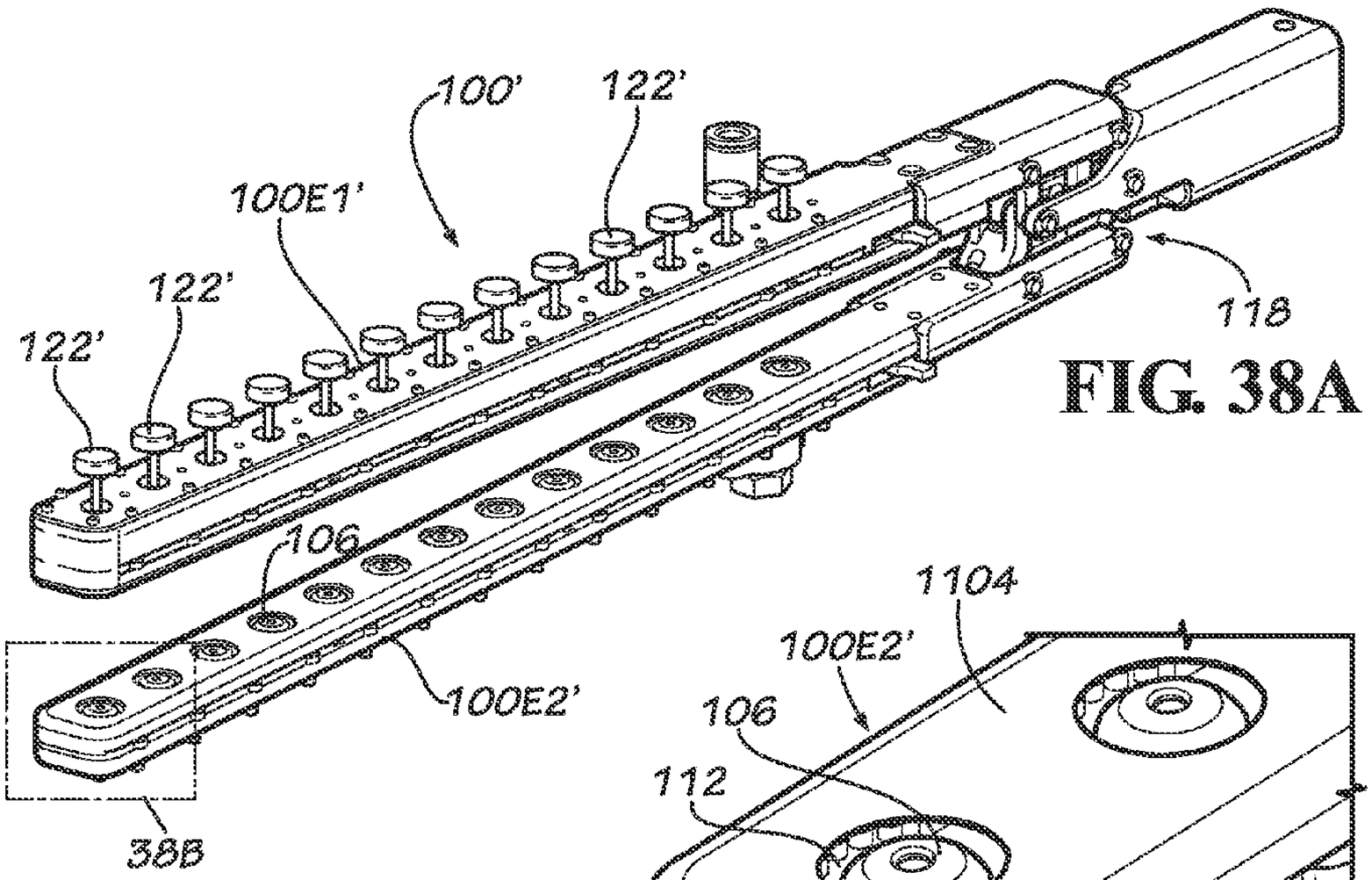

FIG. 38A

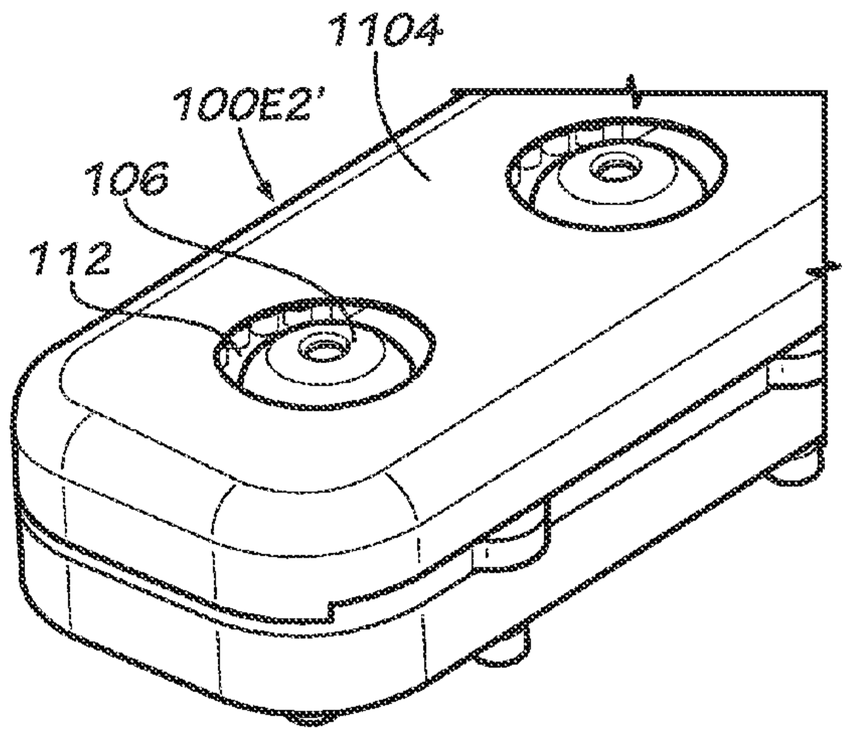

FIG. 38B

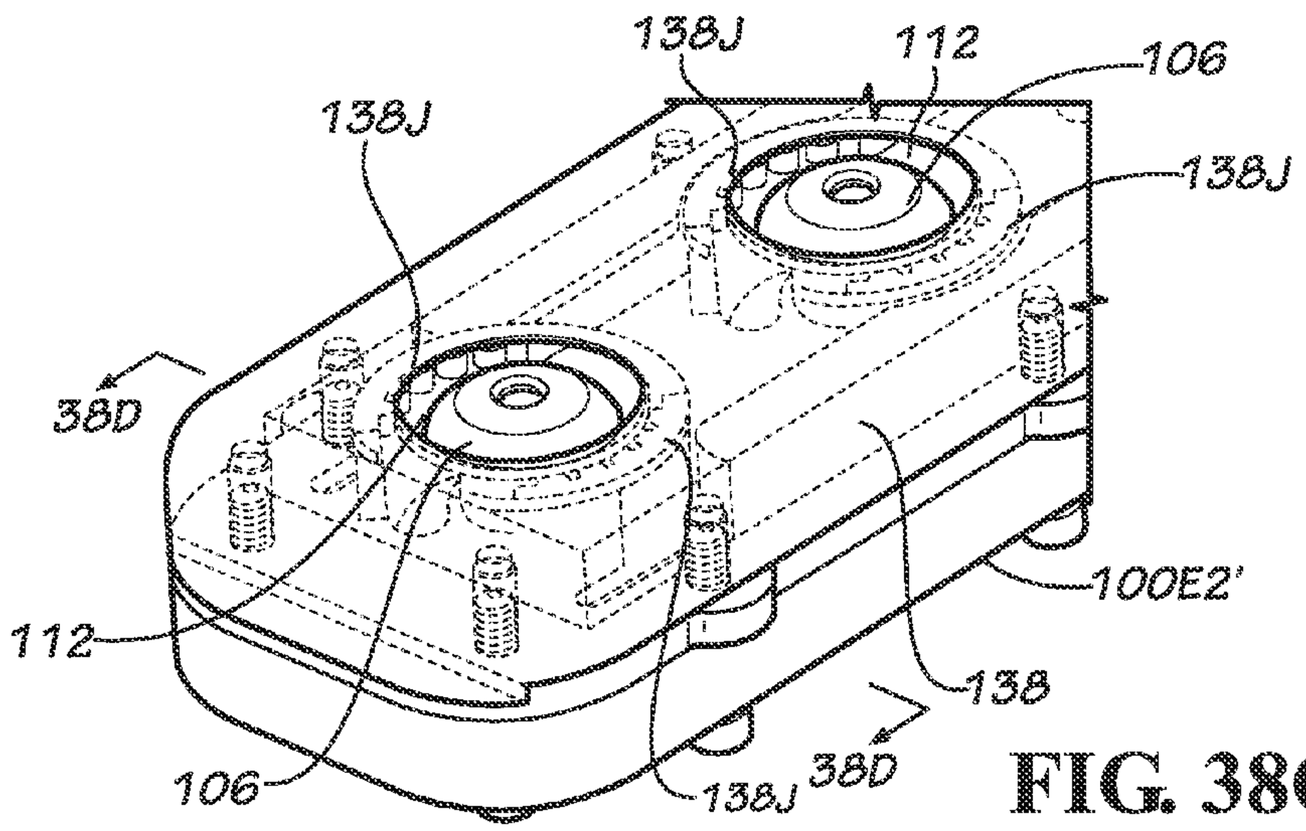

FIG. 38C

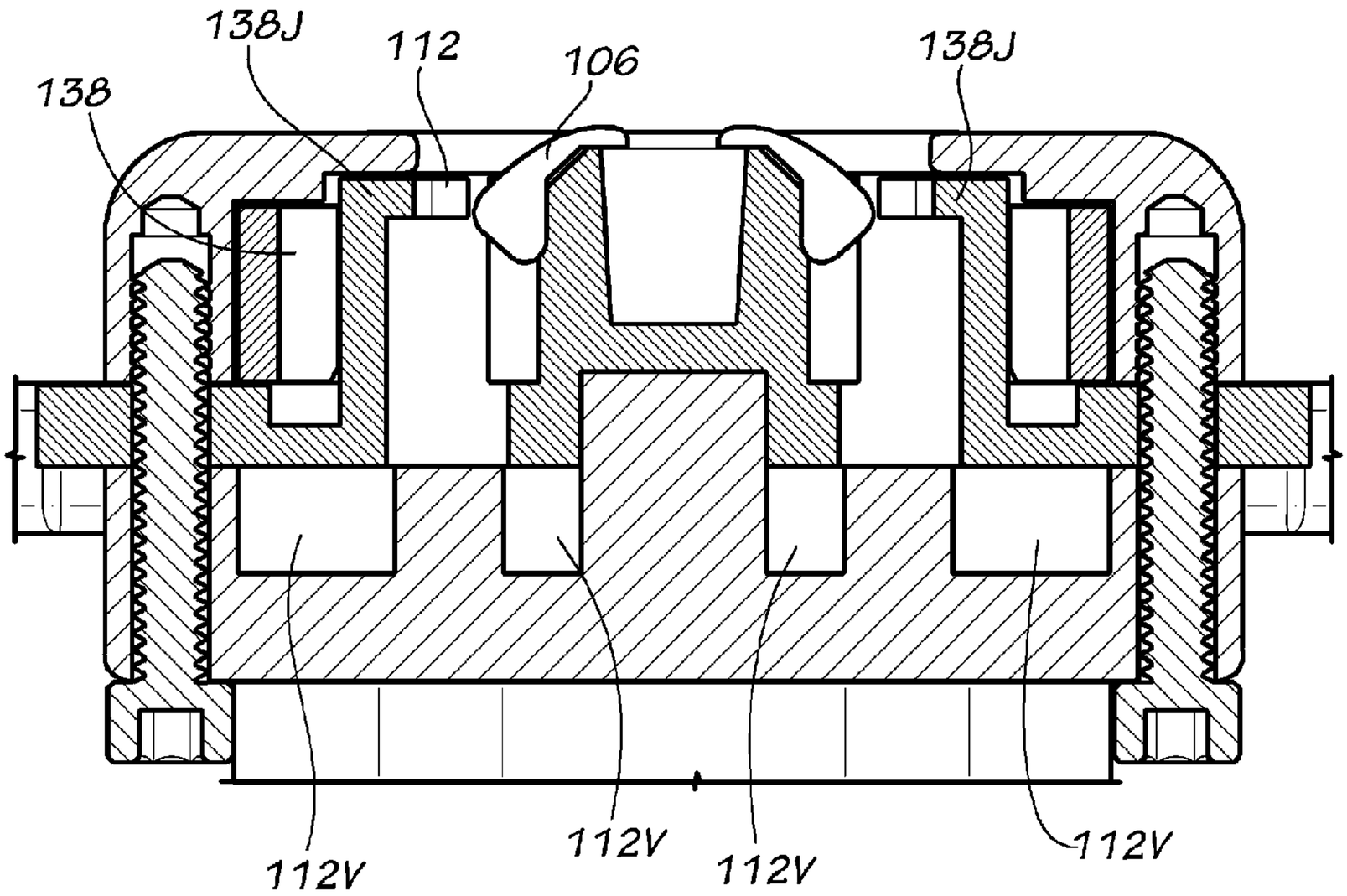

FIG. 38D

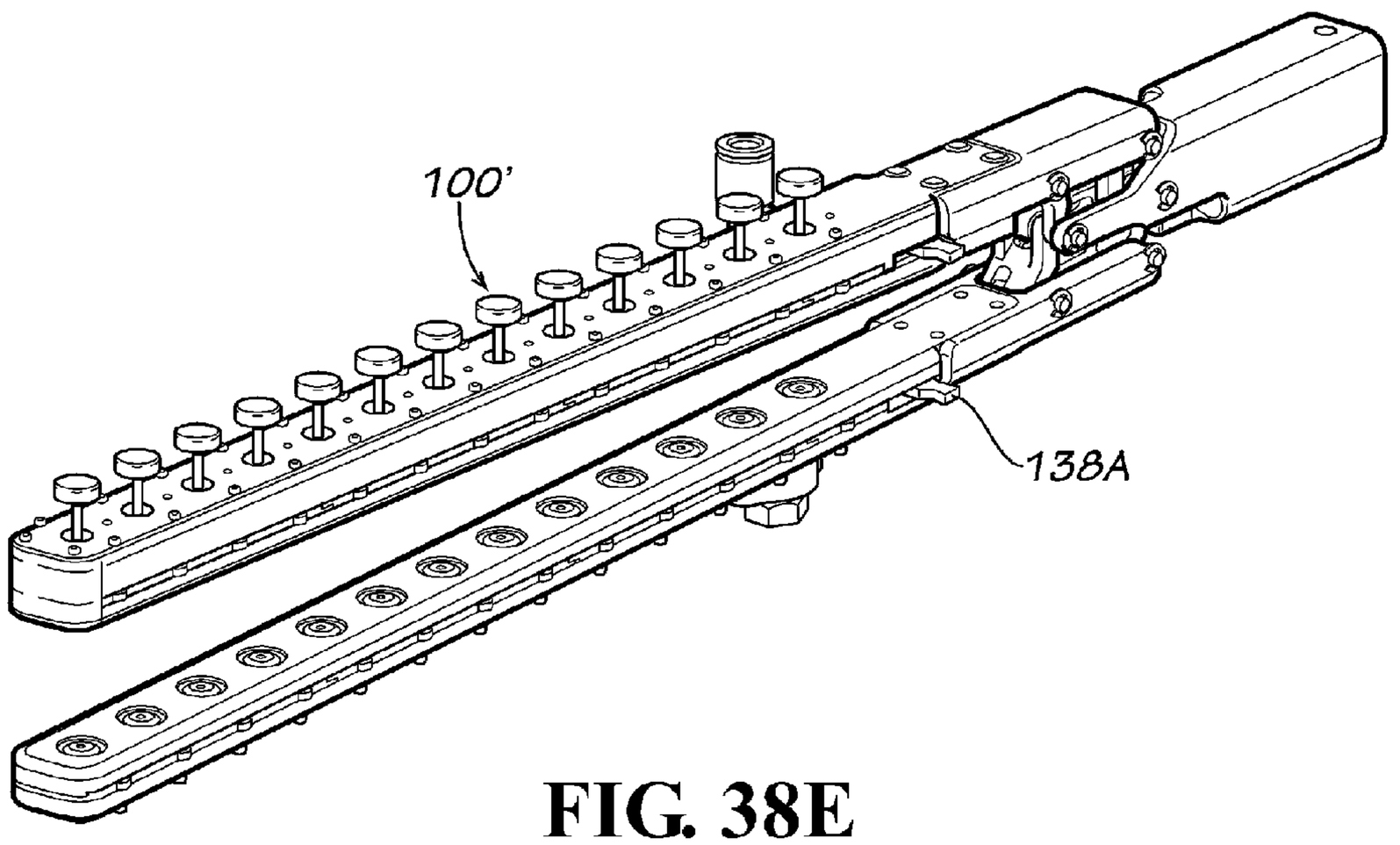

FIG. 38E

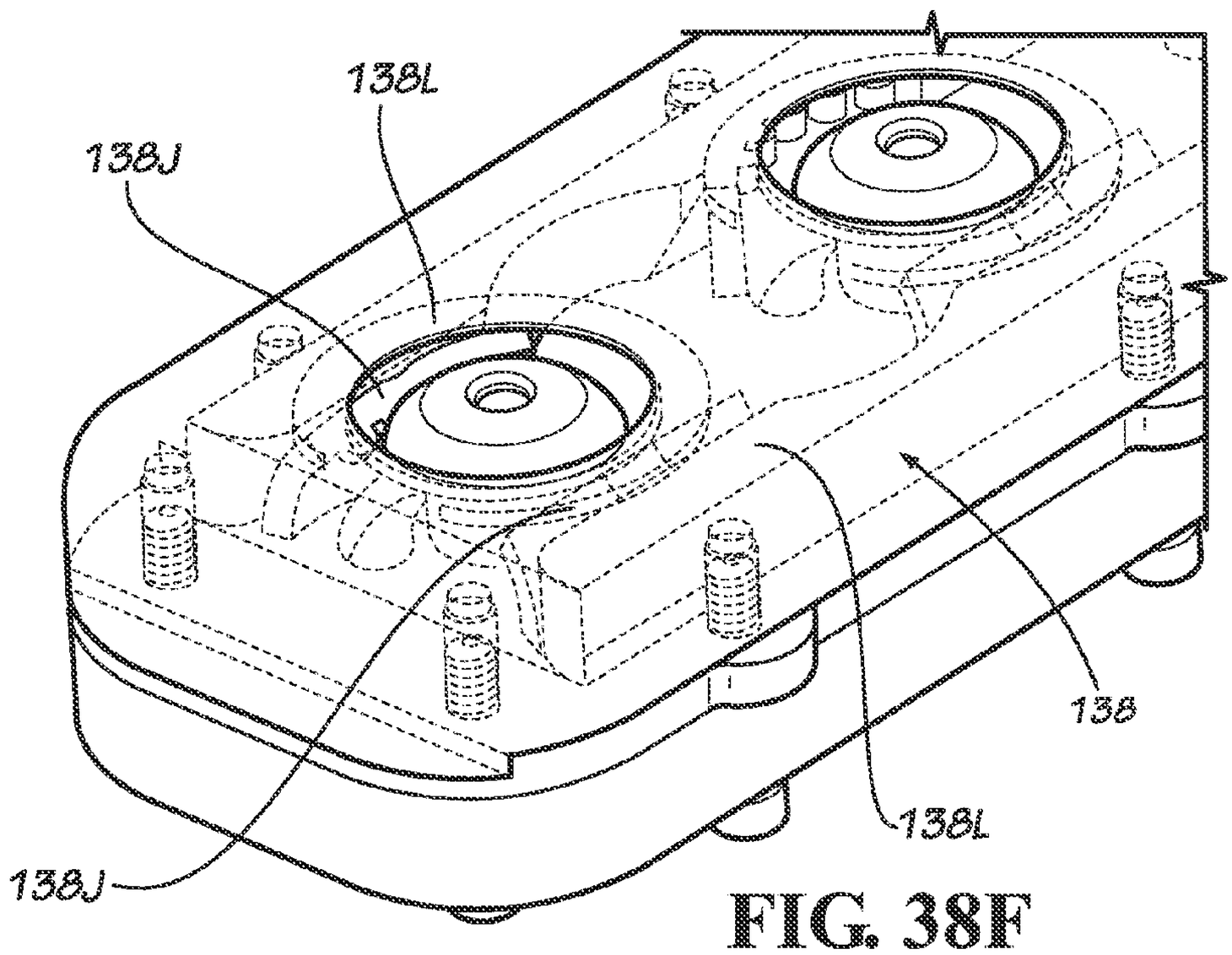

FIG. 38F

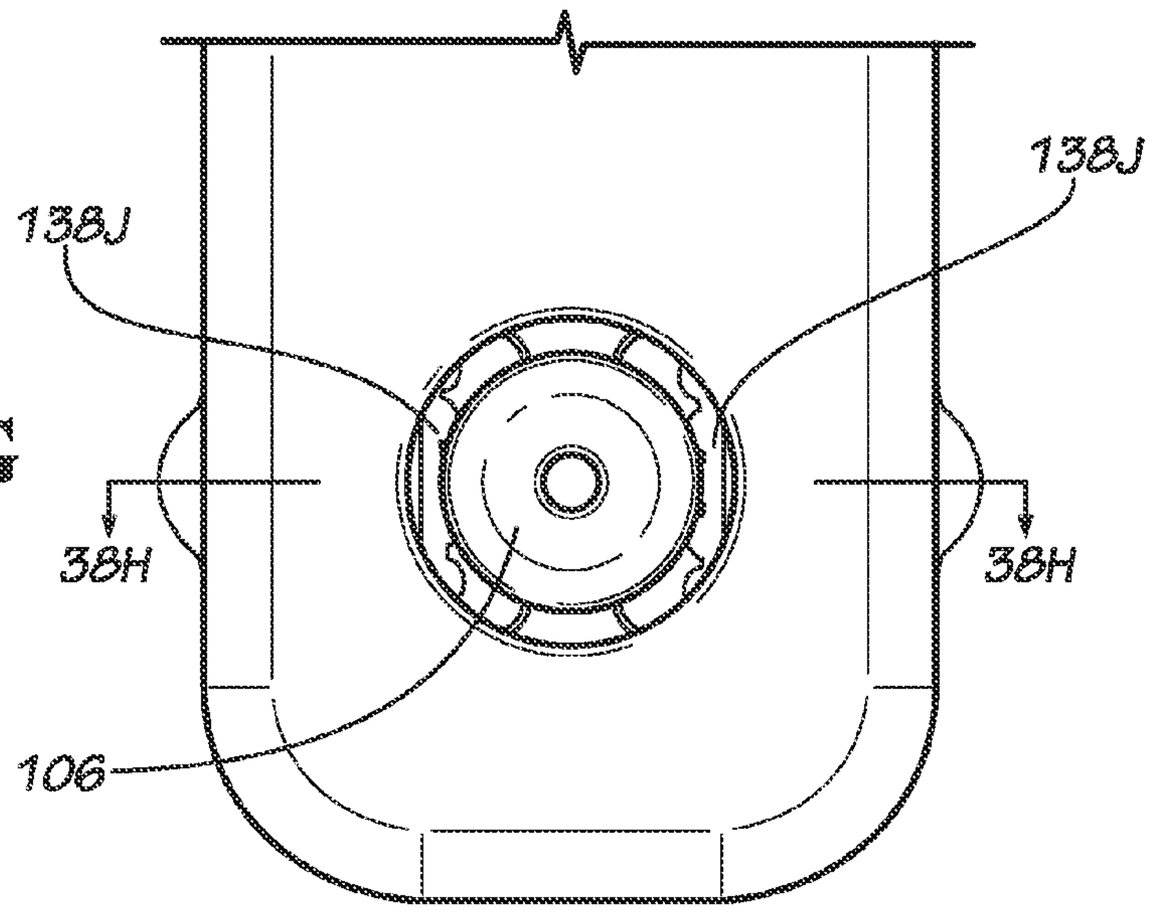

FIG. 38G

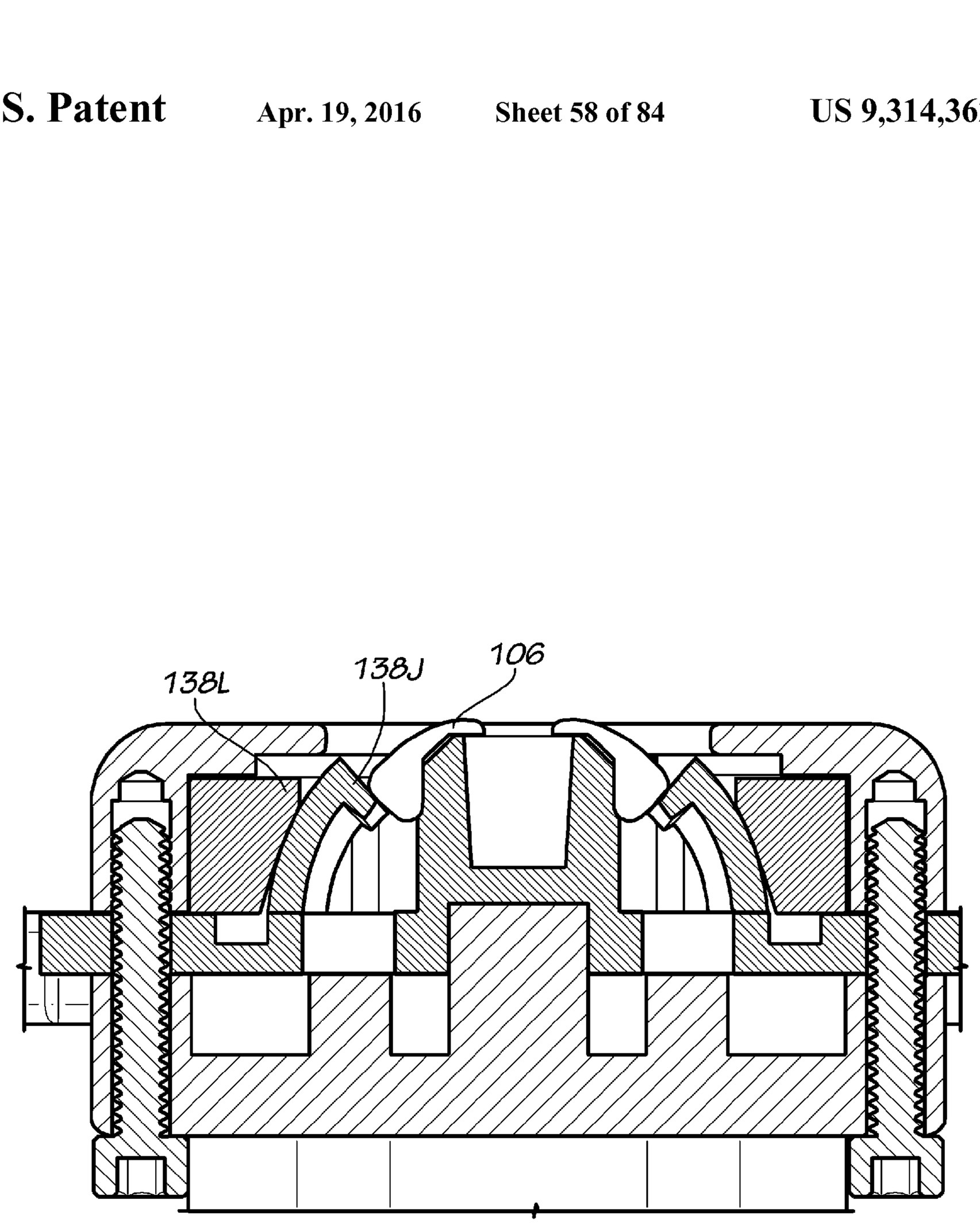

FIG. 38H

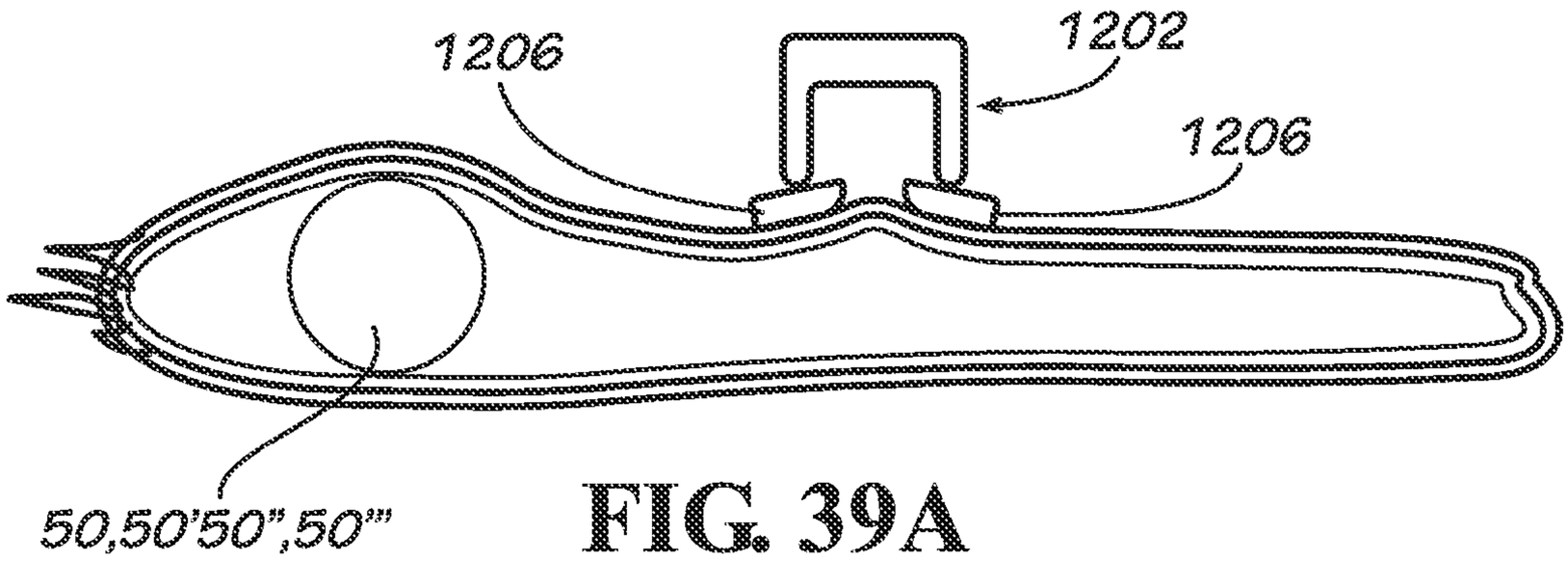

FIG. 39A

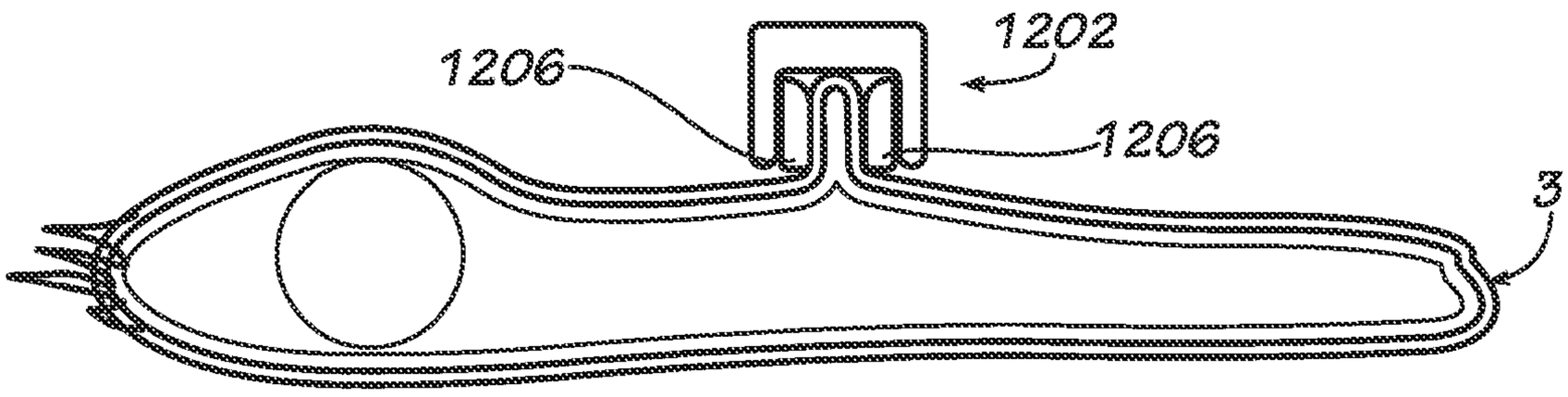

FIG. 39B

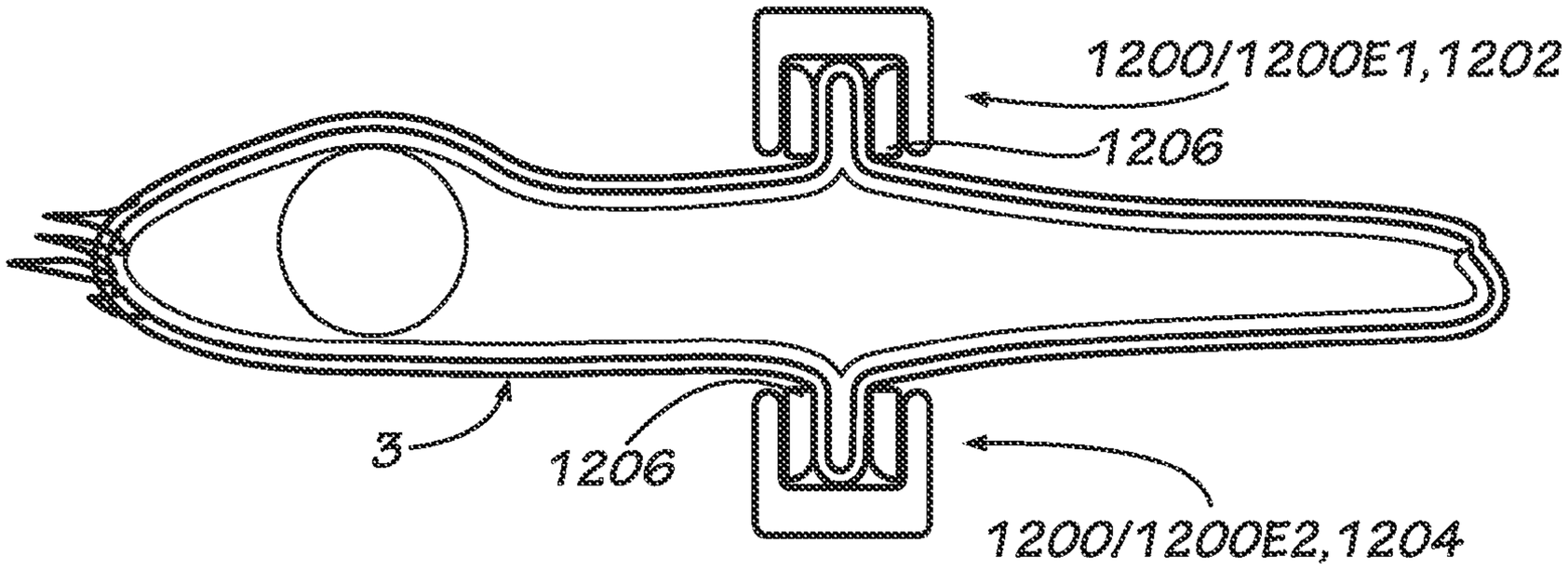

FIG. 39C

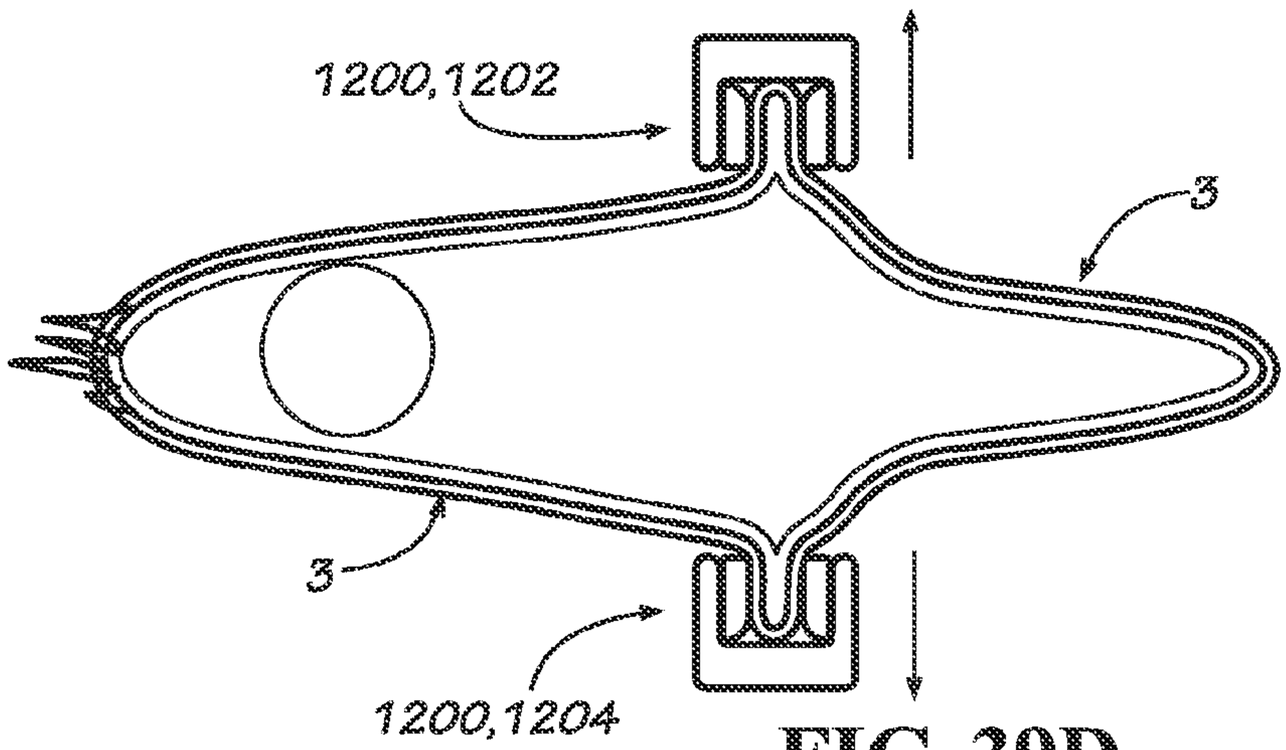

FIG. 39D

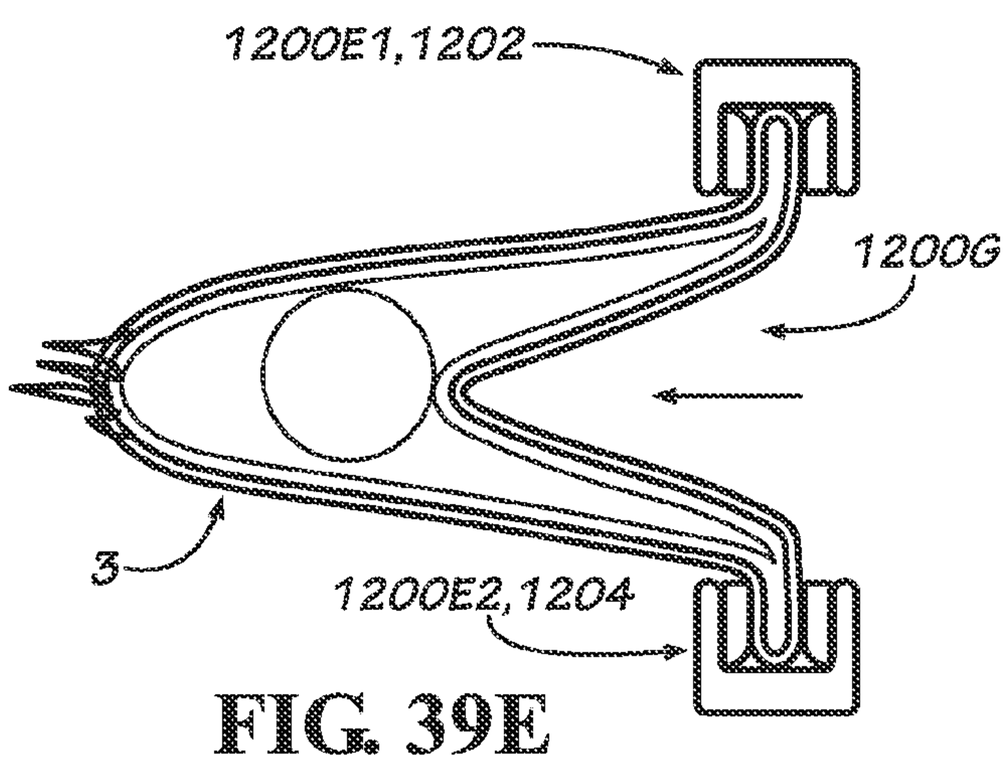

FIG. 39E

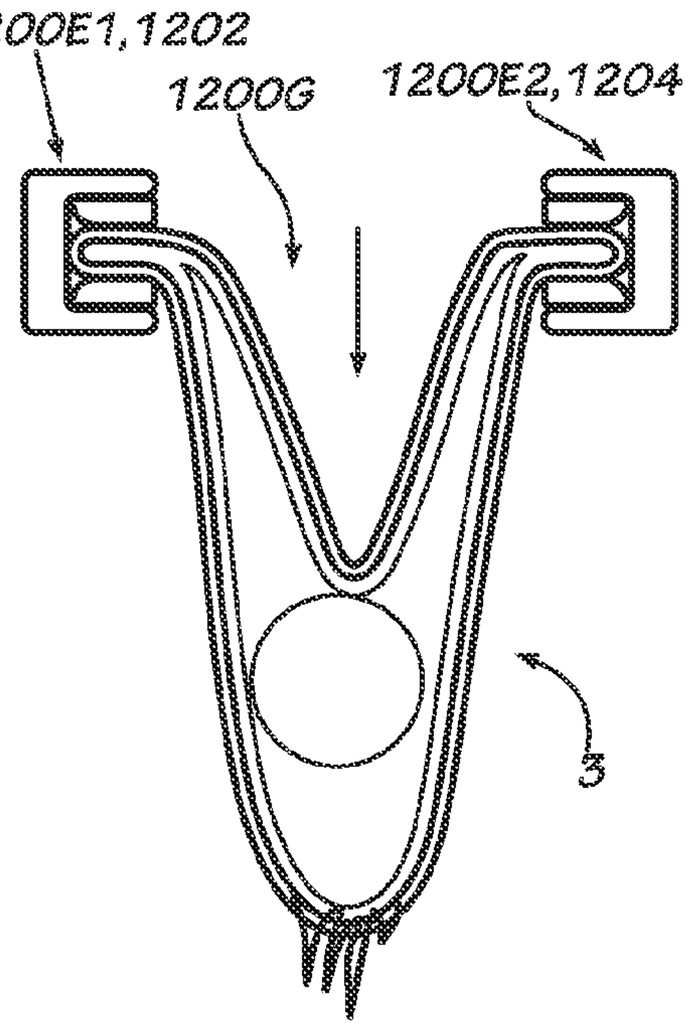

FIG. 39E'

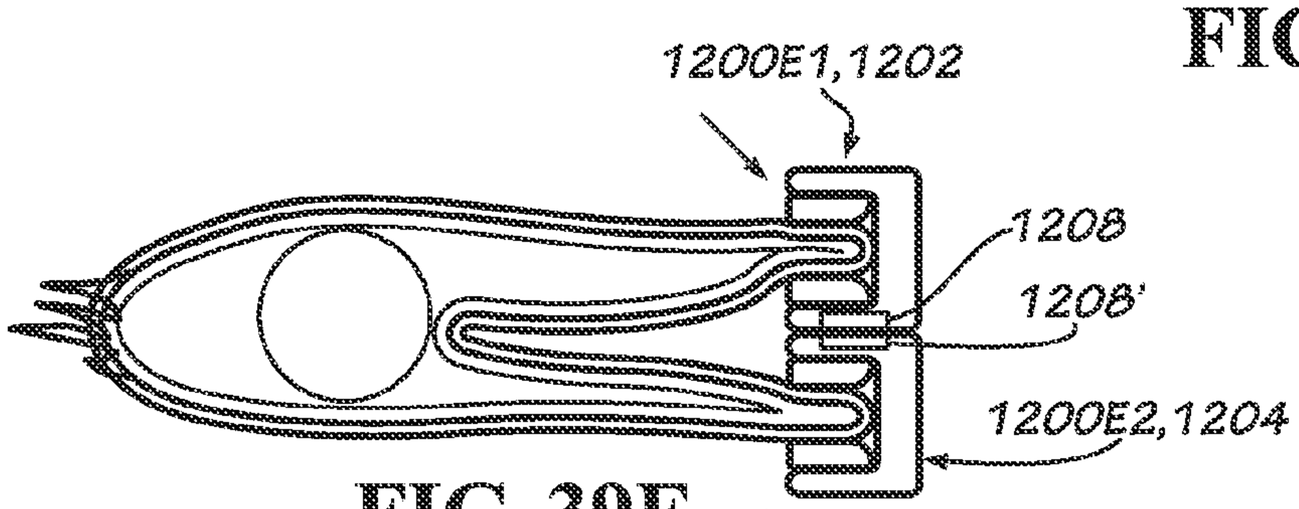

FIG. 39F

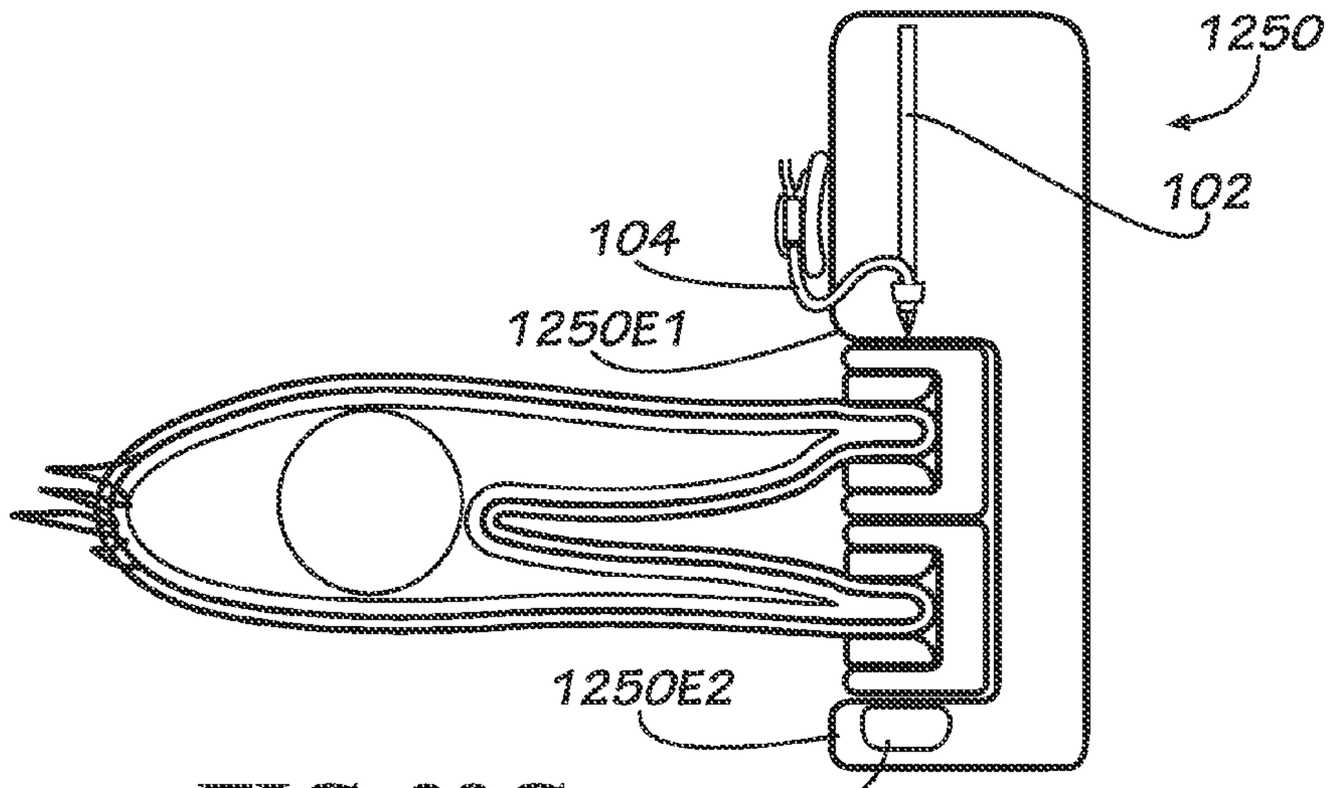

FIG. 39G

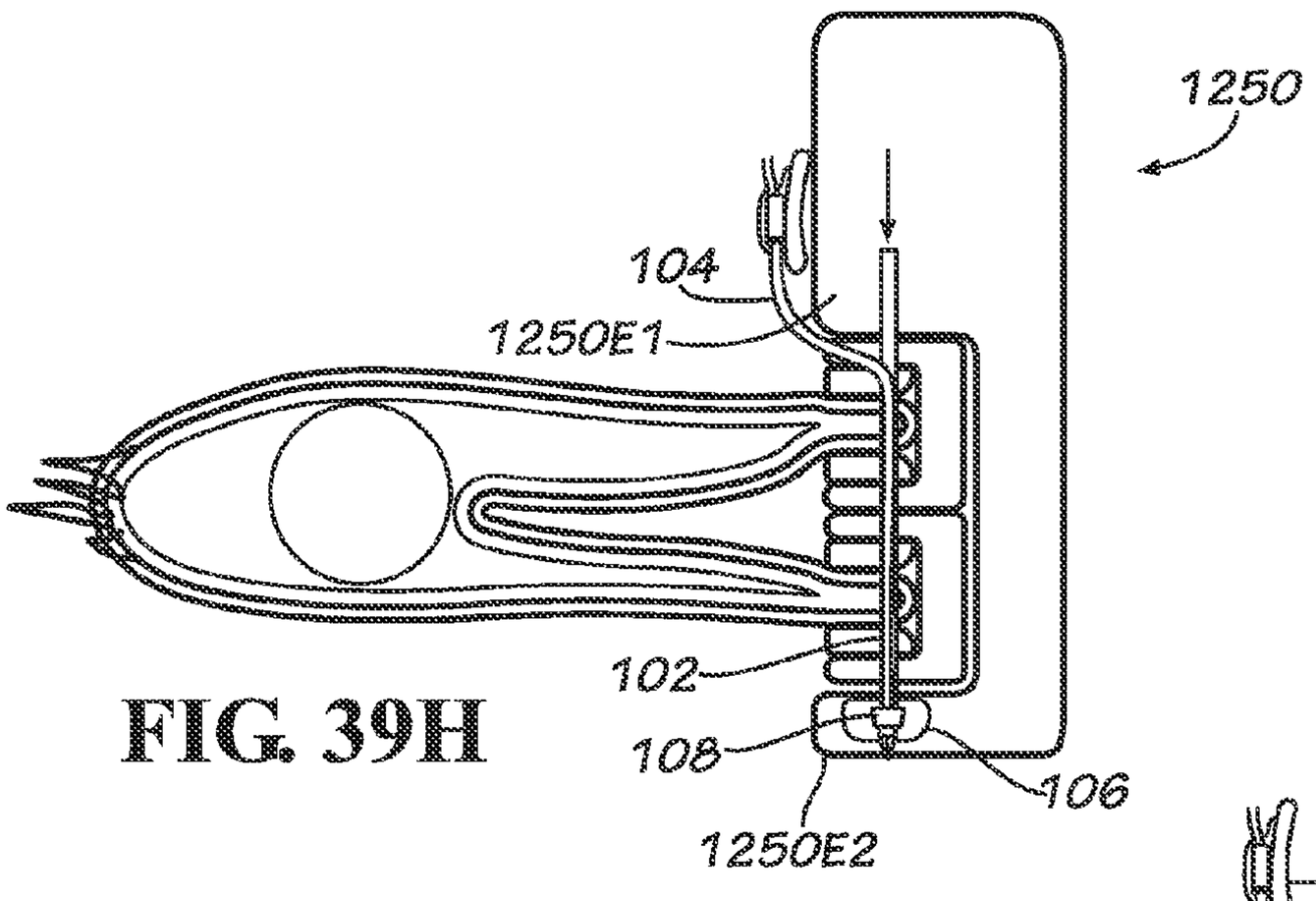

FIG. 39H

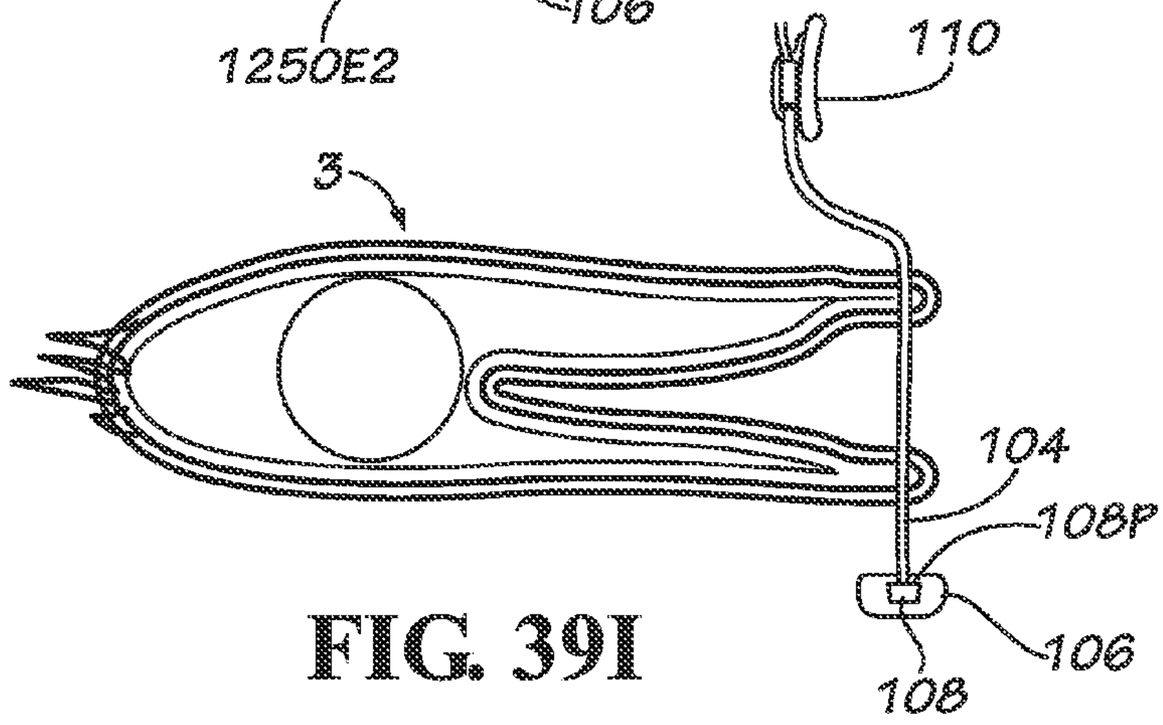

FIG. 39I

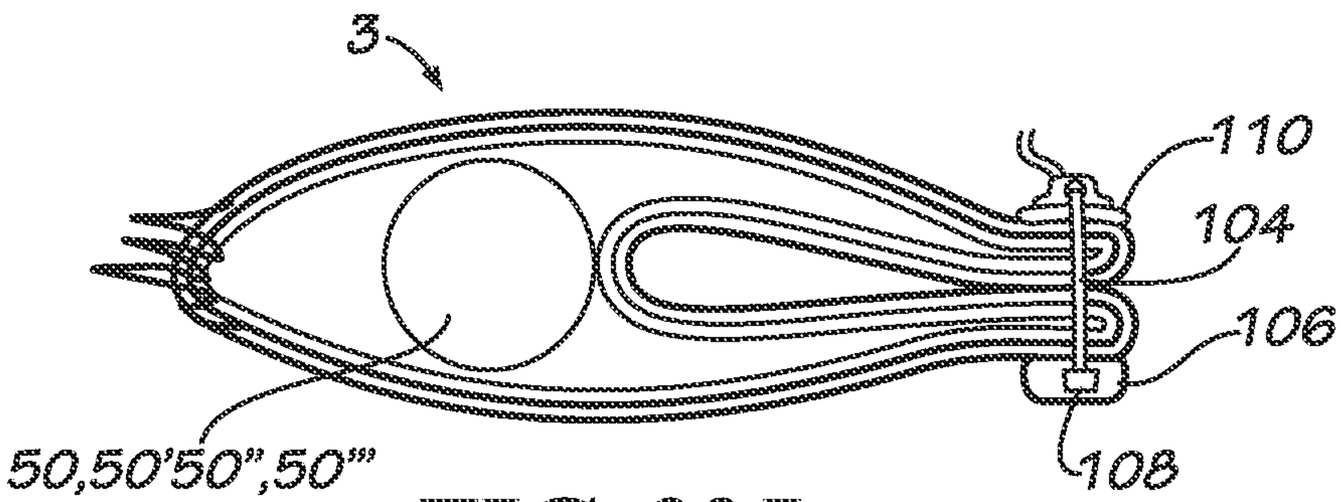

FIG. 39J

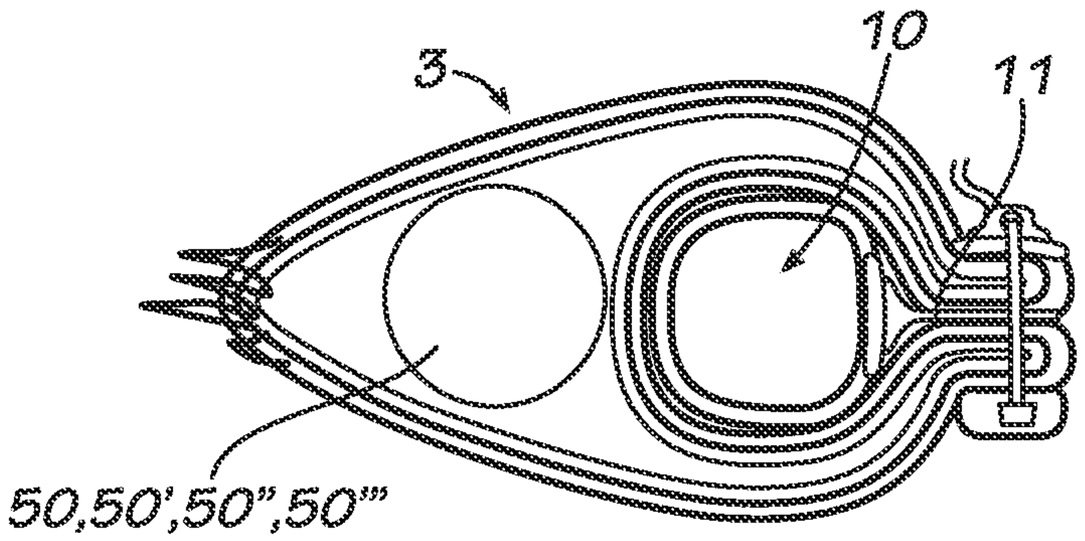

FIG. 39K

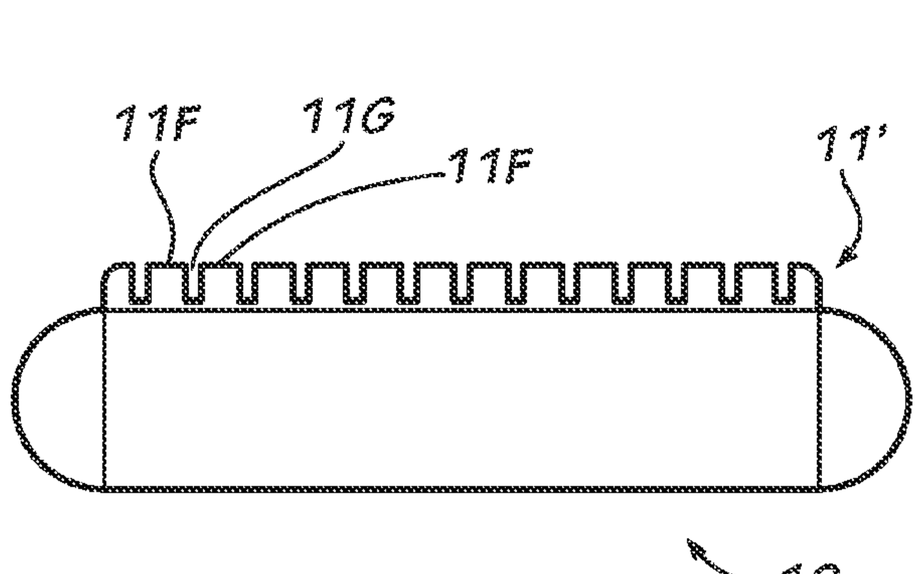

FIG. 40A

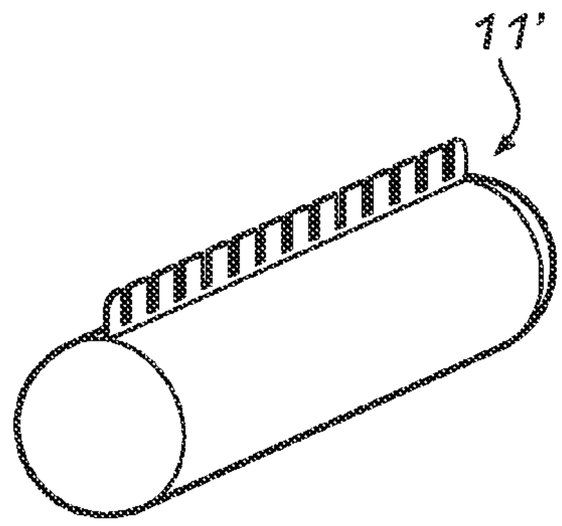

FIG. 40B

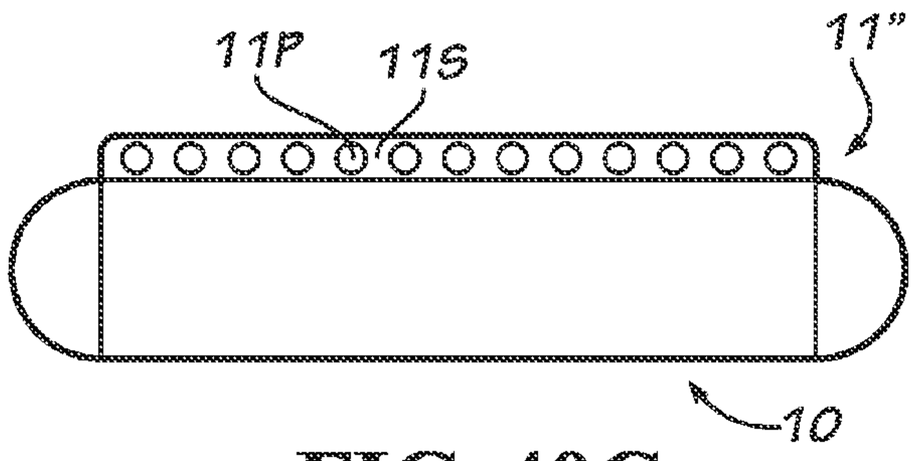

FIG. 40C

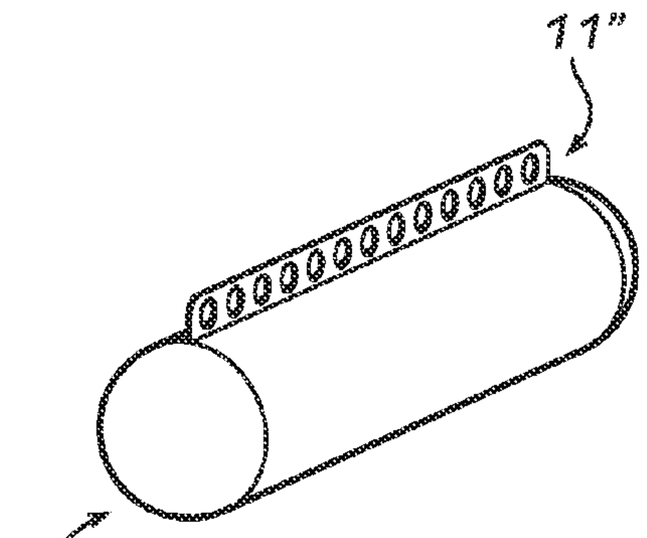

FIG. 40D

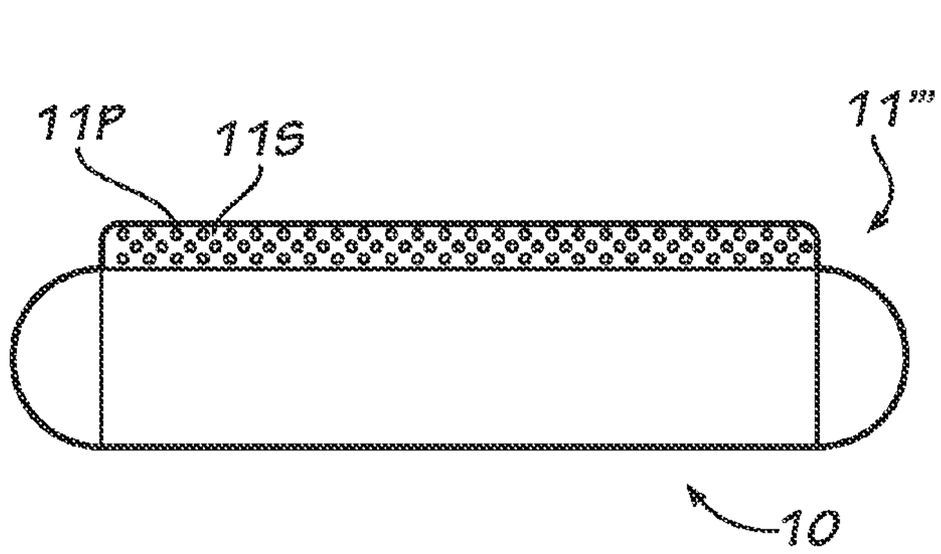

FIG. 40E

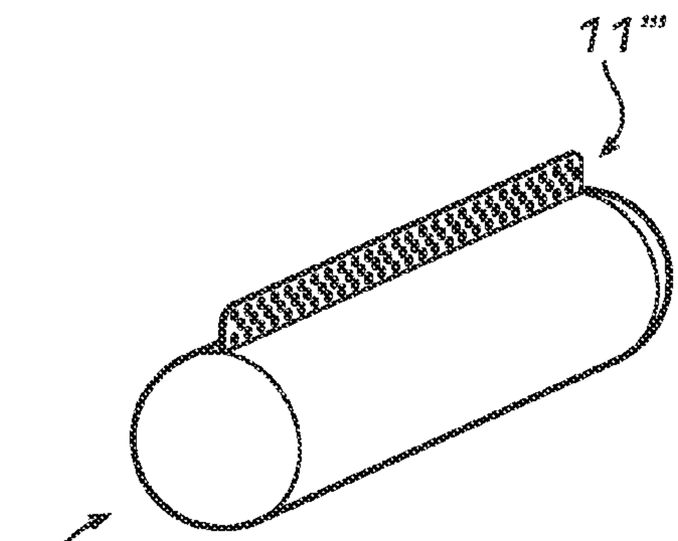

FIG. 40F

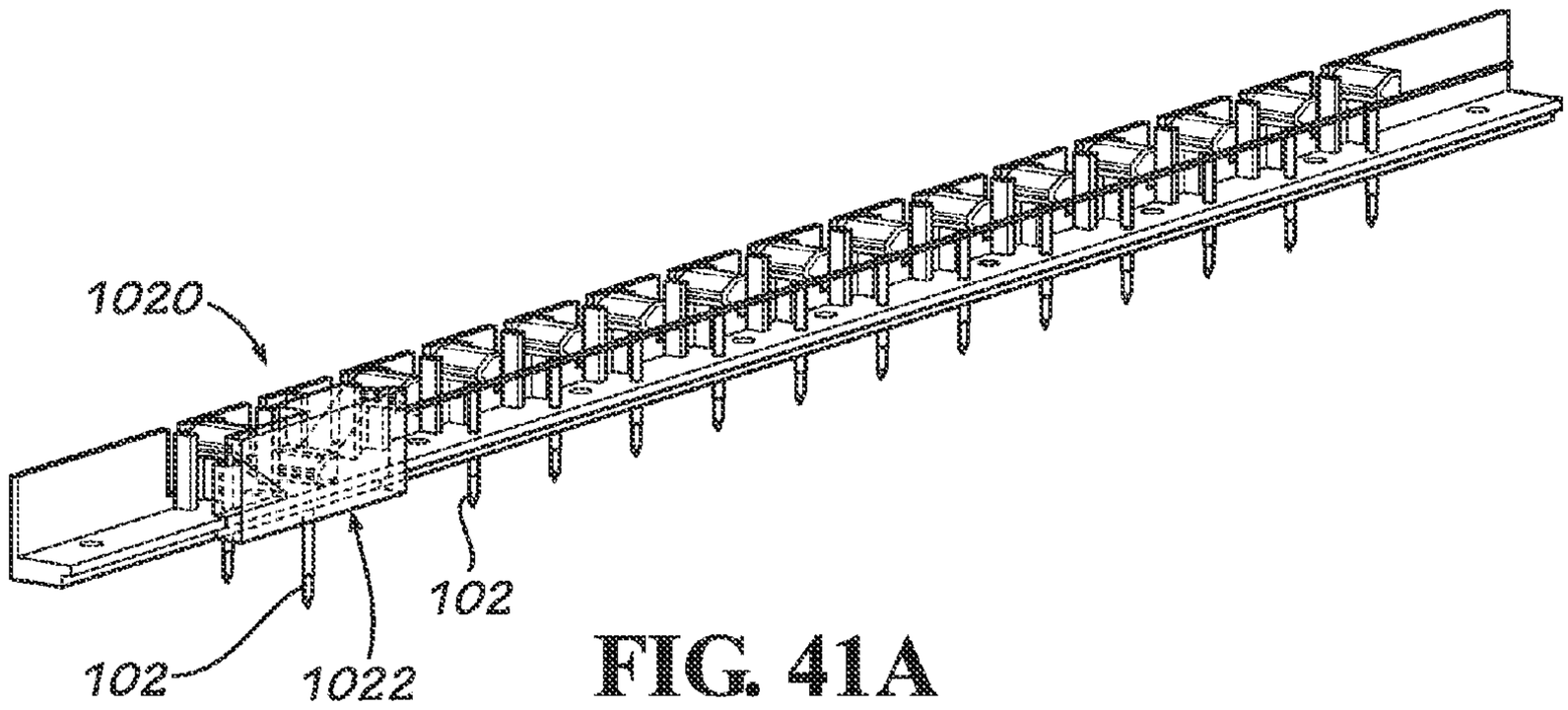

FIG. 41A

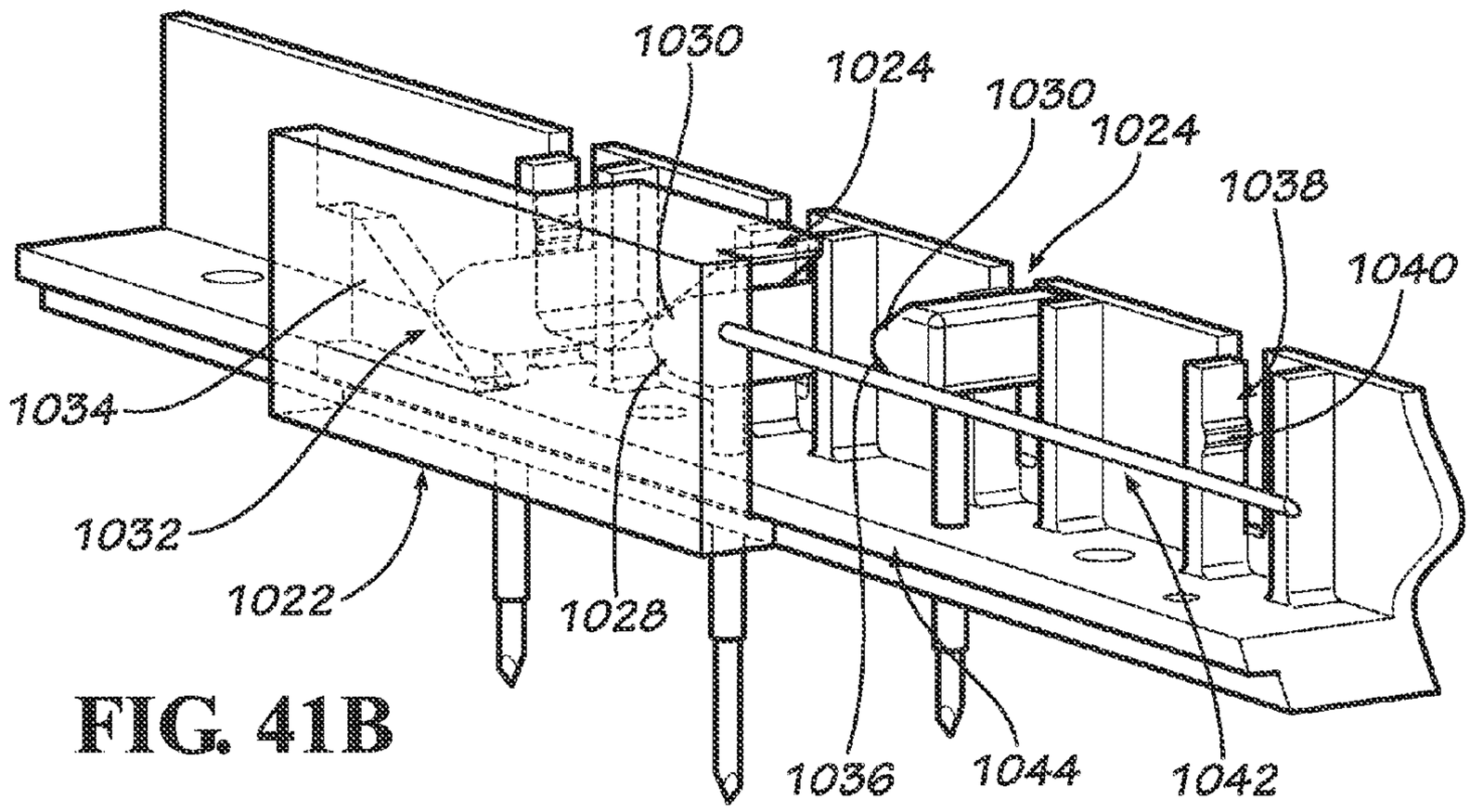

FIG. 41B

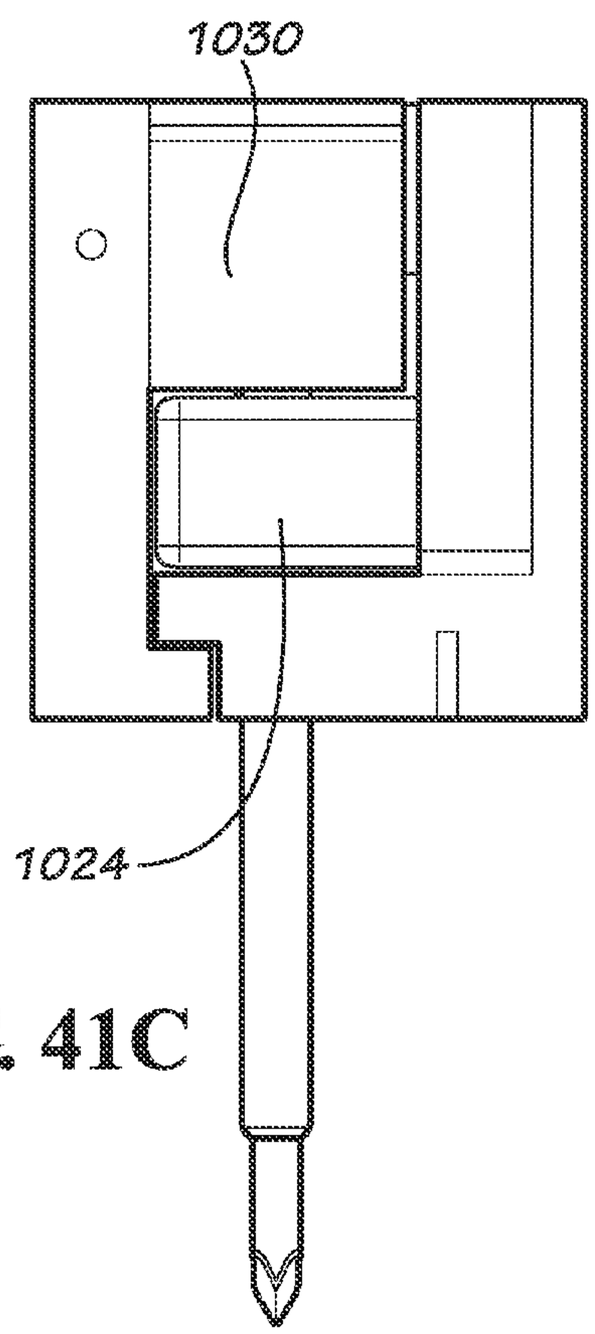

FIG. 41C

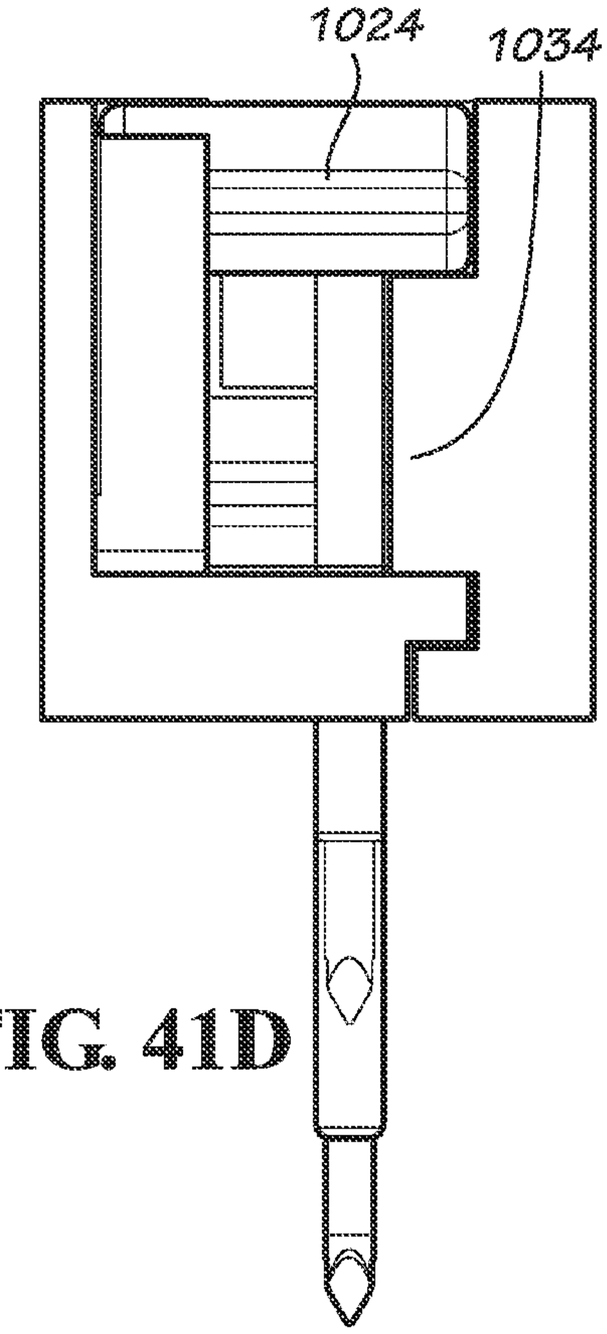

FIG. 41D

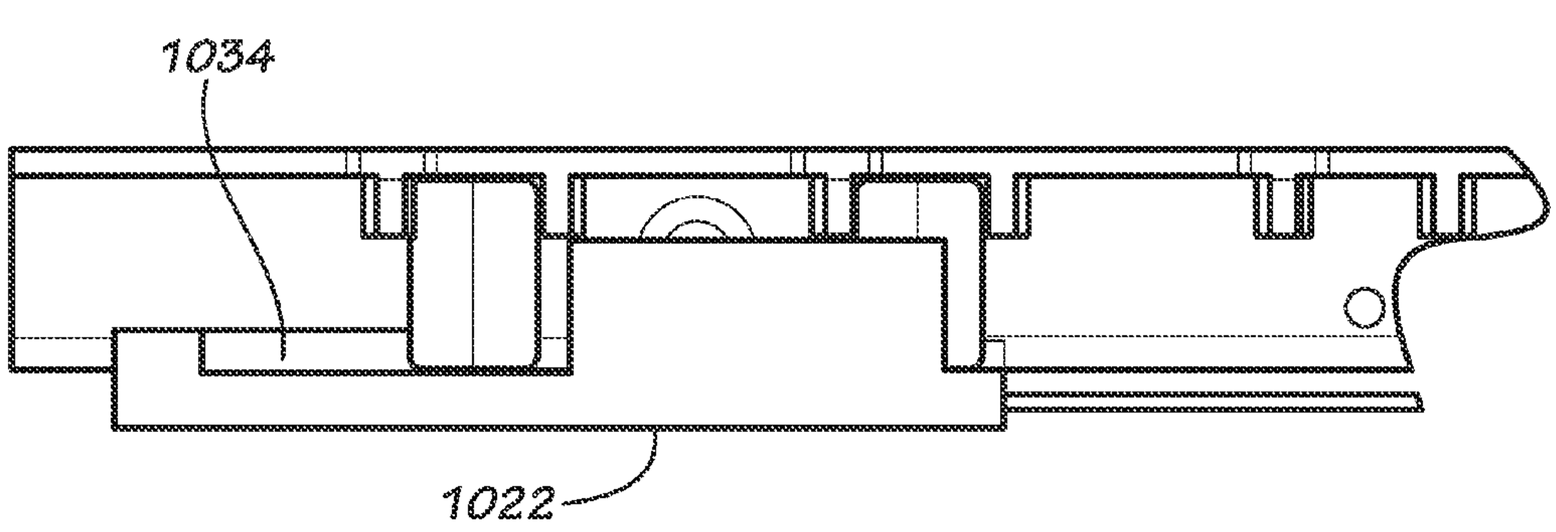

FIG. 41E

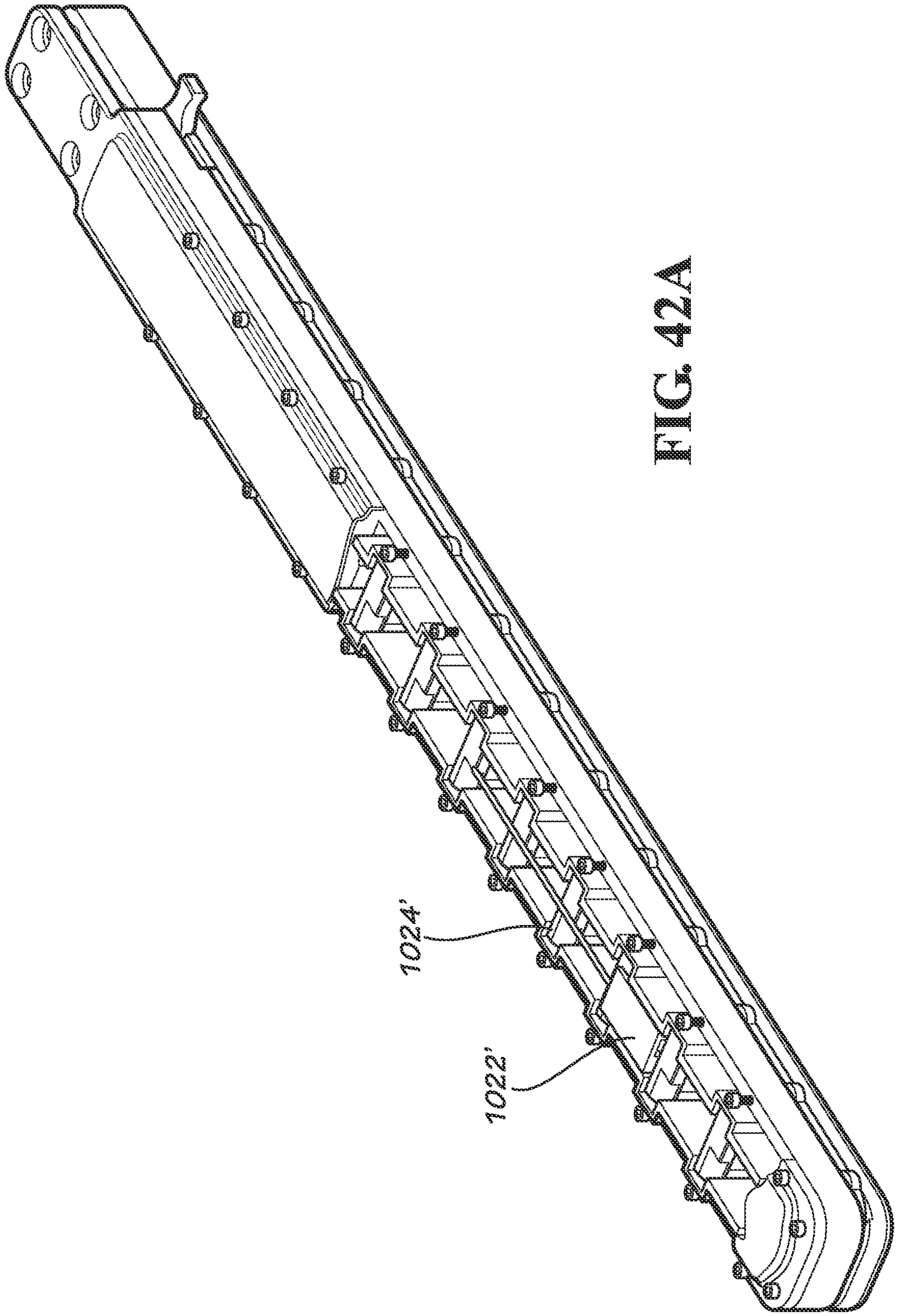

FIG. 42A

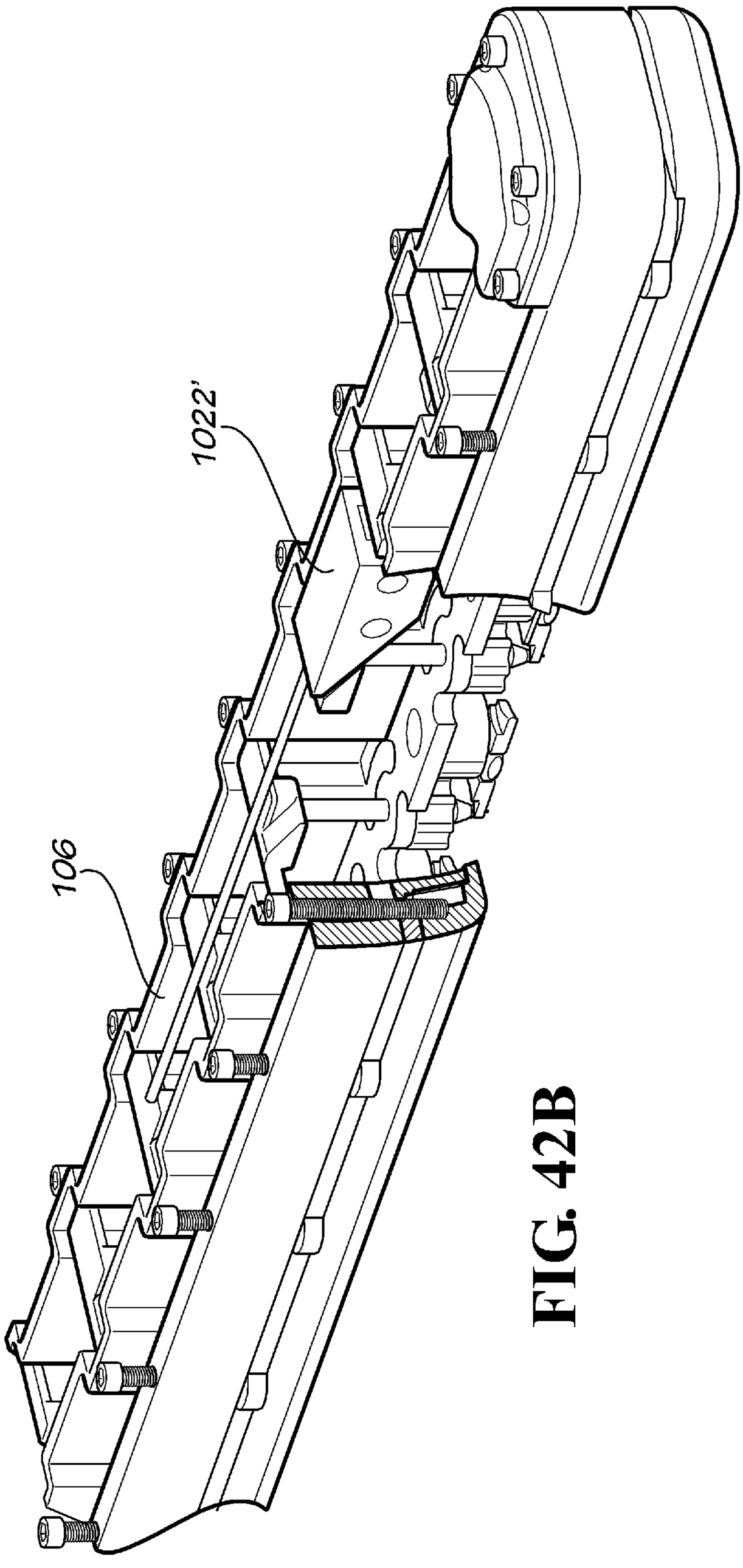

FIG. 42B

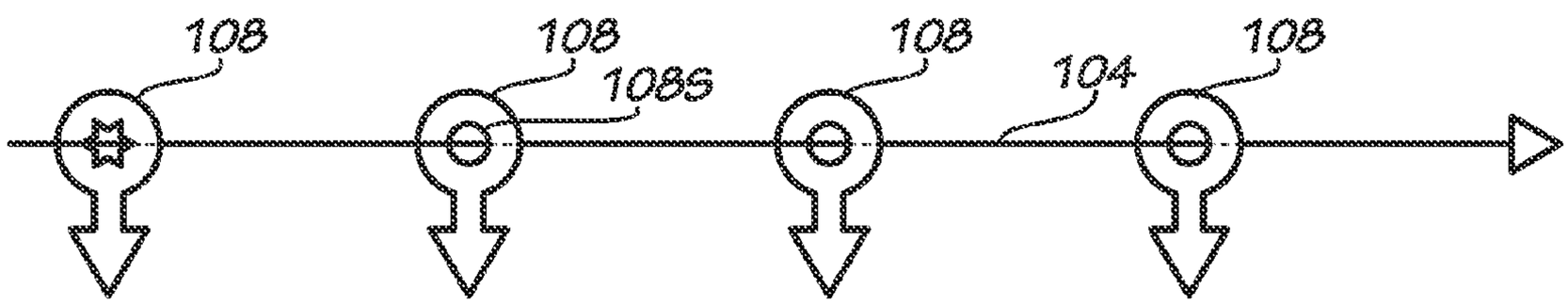

FIG. 43A

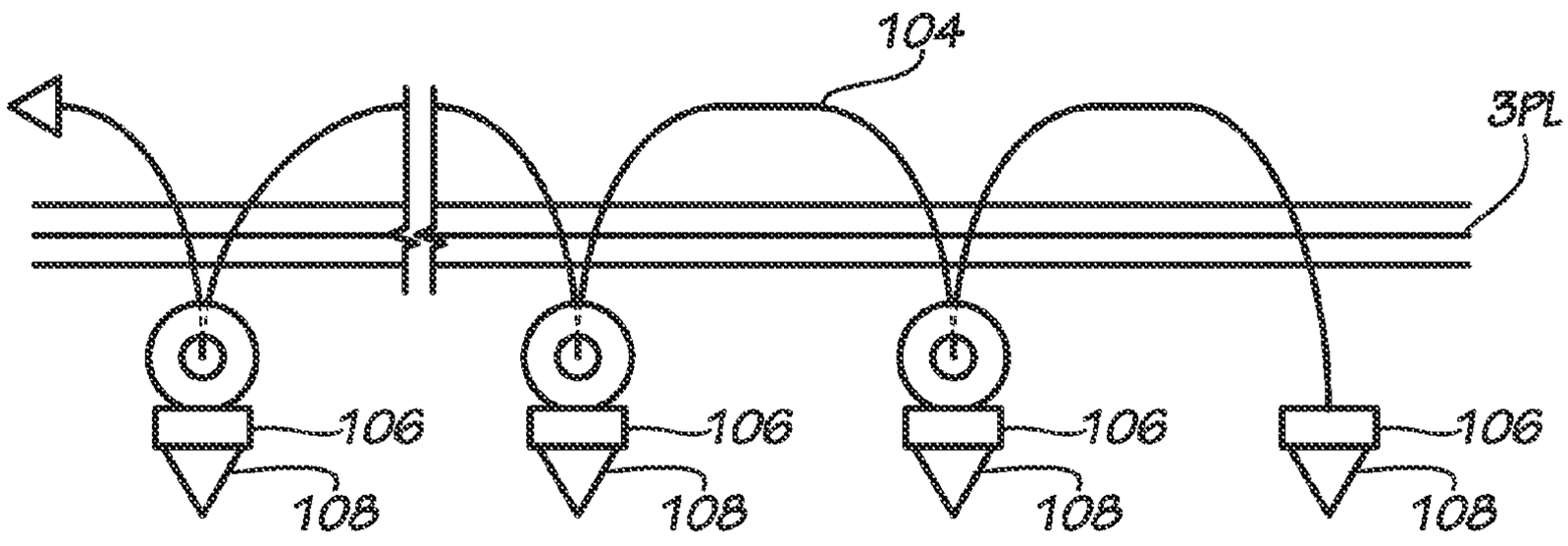

FIG. 43B

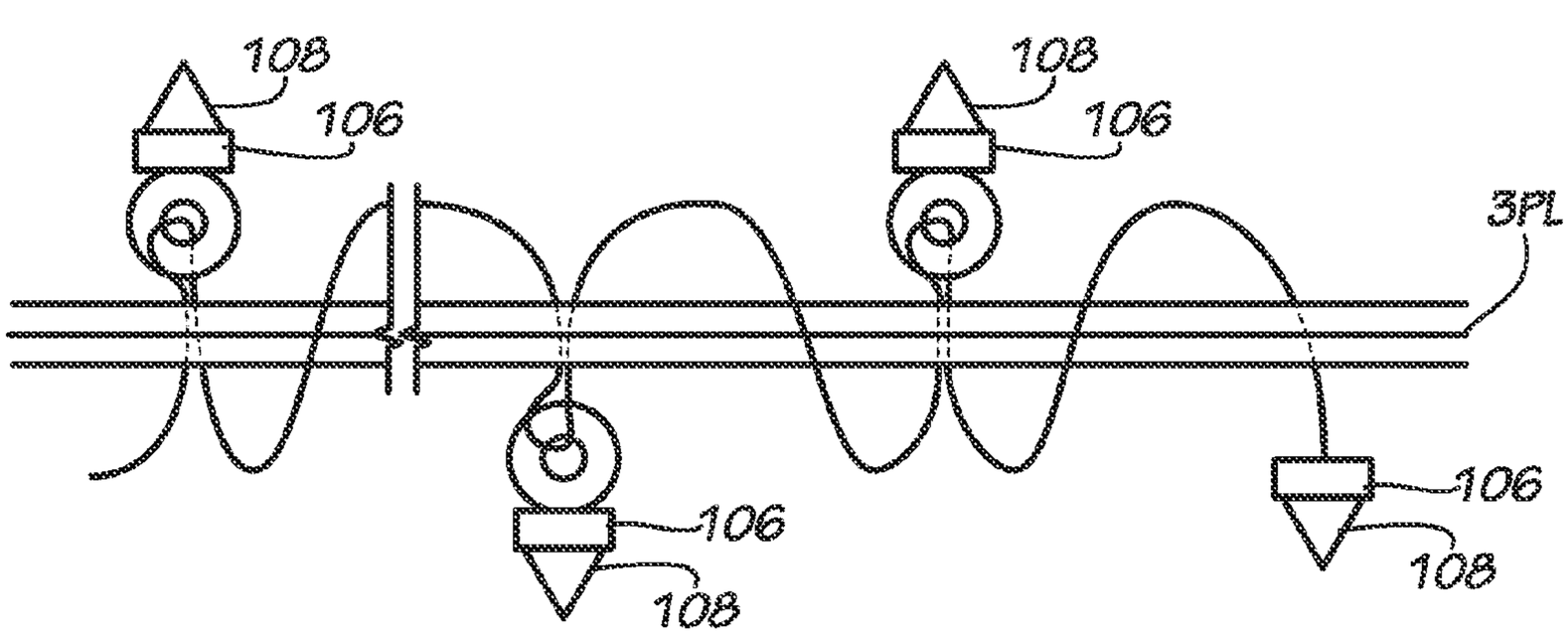

FIG. 43C

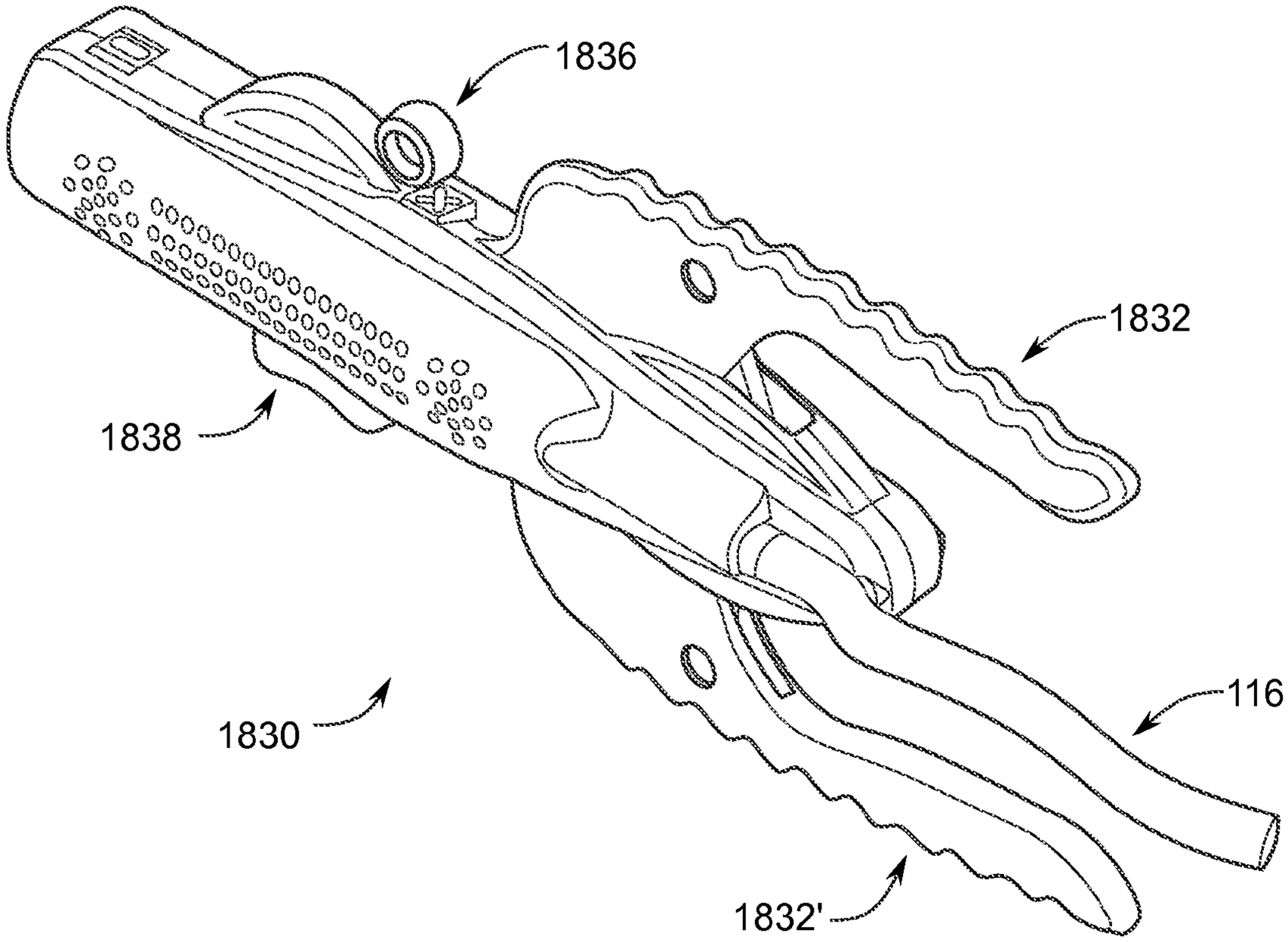

FIG. 44A

FIG. 44B

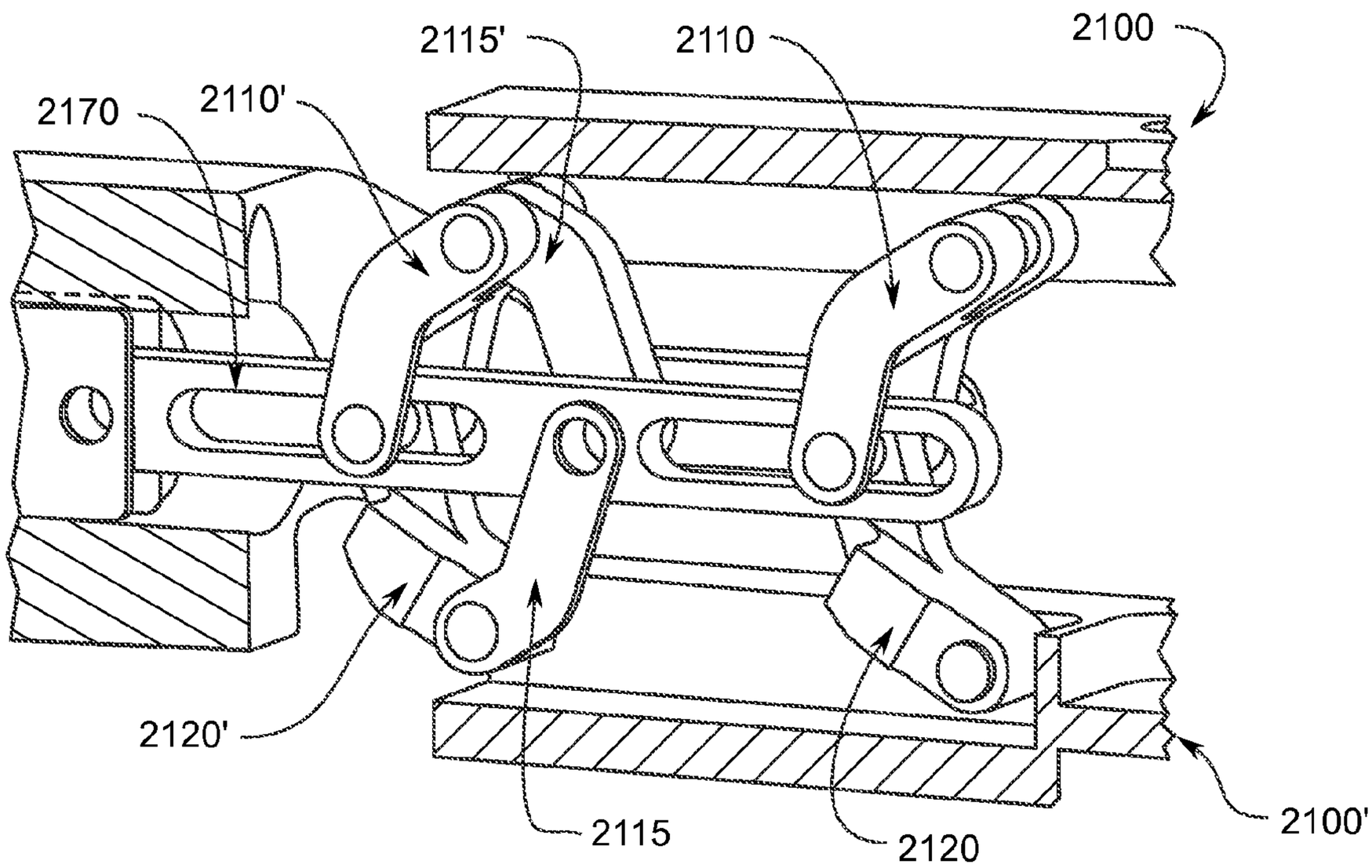

FIG. 45A

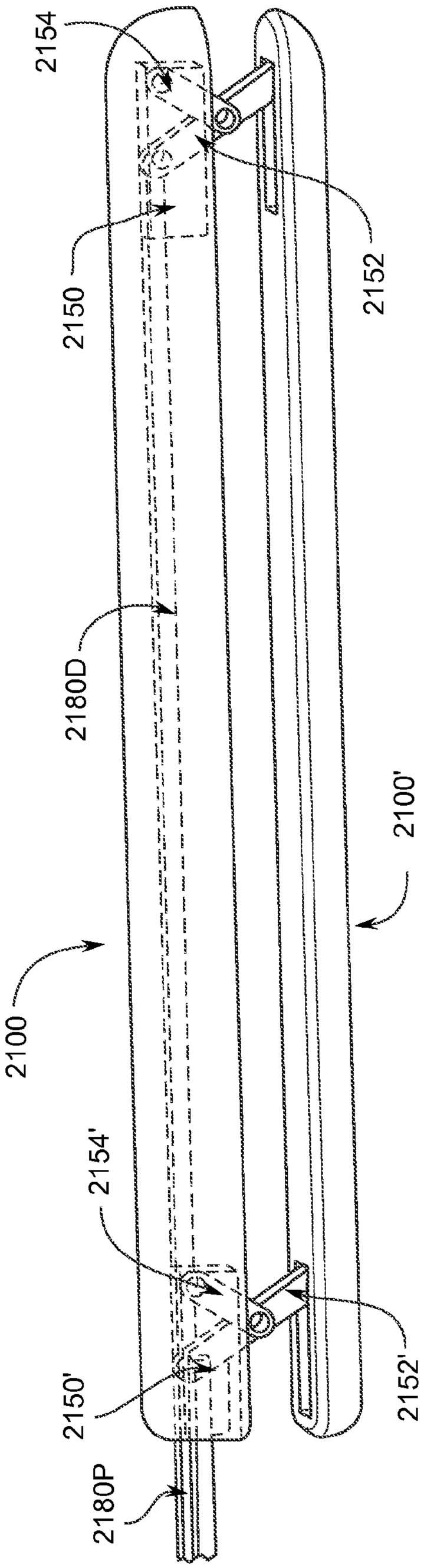

FIG. 45B

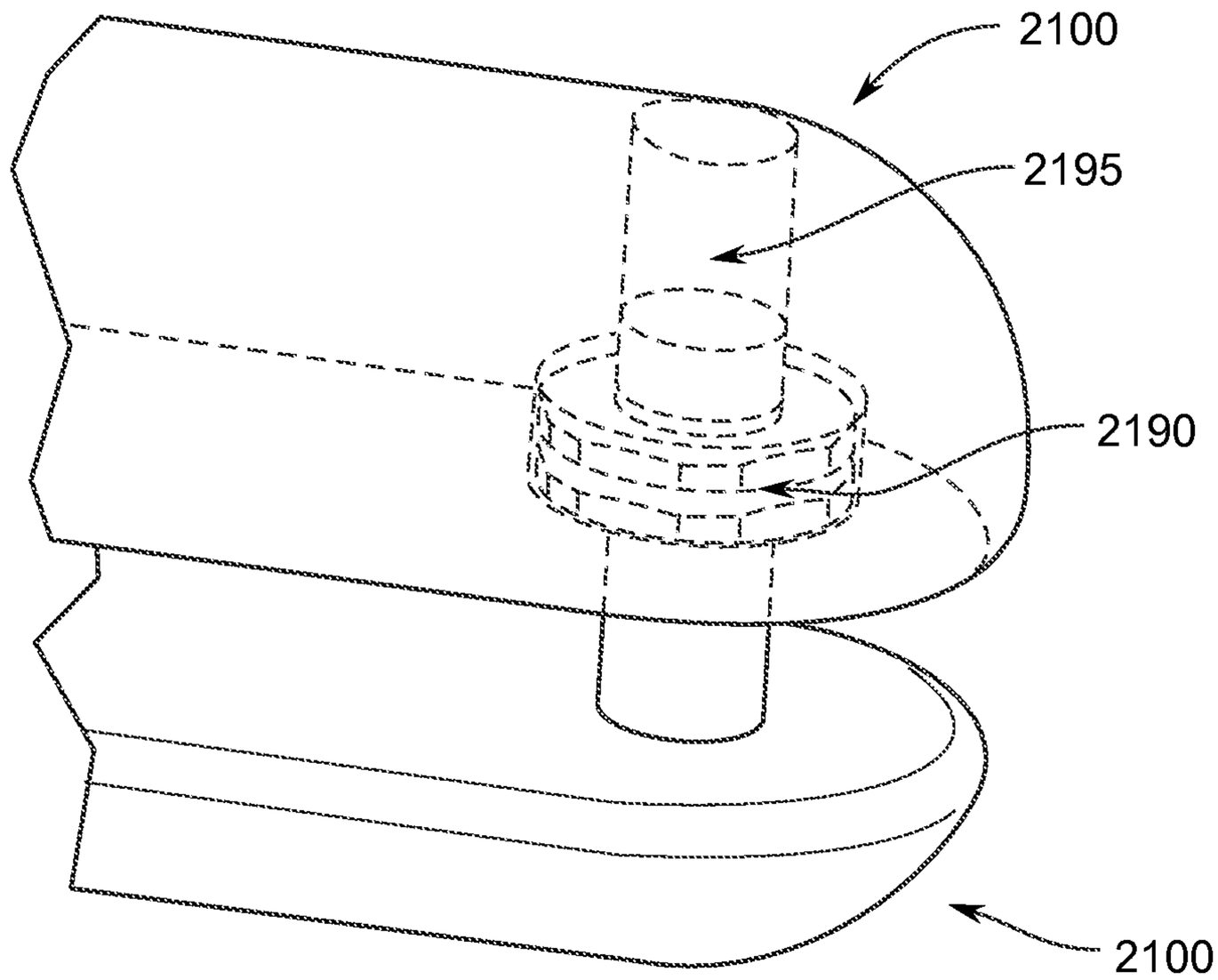

FIG. 45C

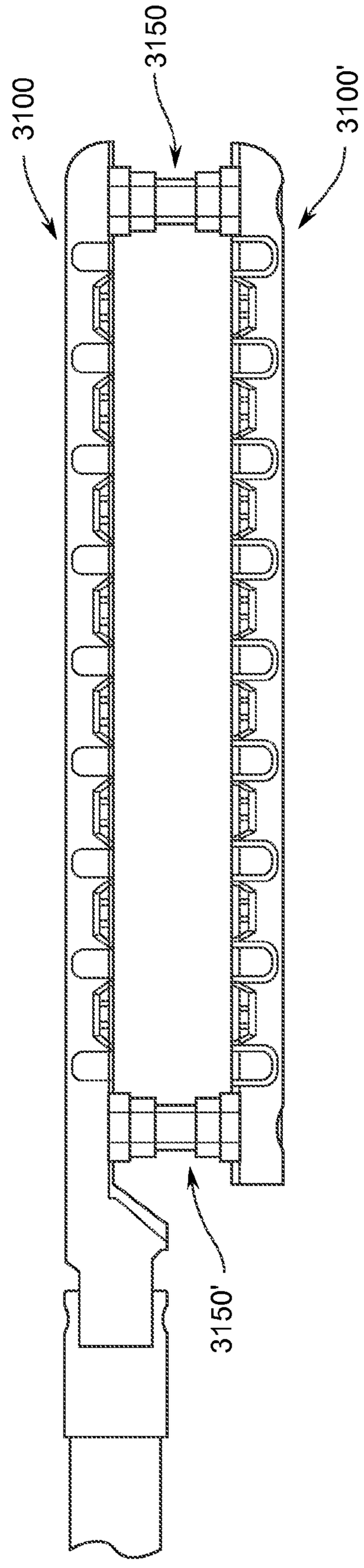

FIG. 46A

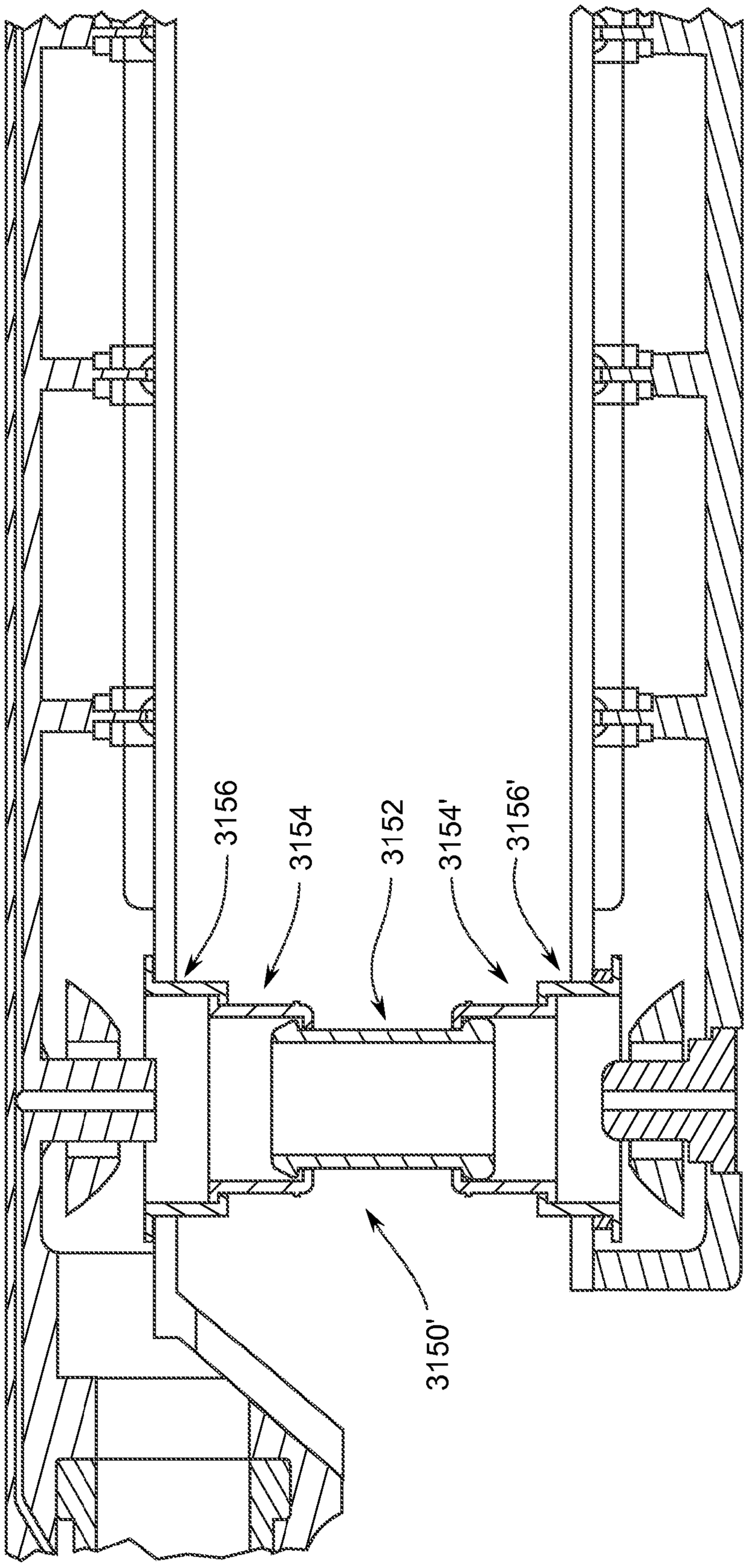

FIG. 46B

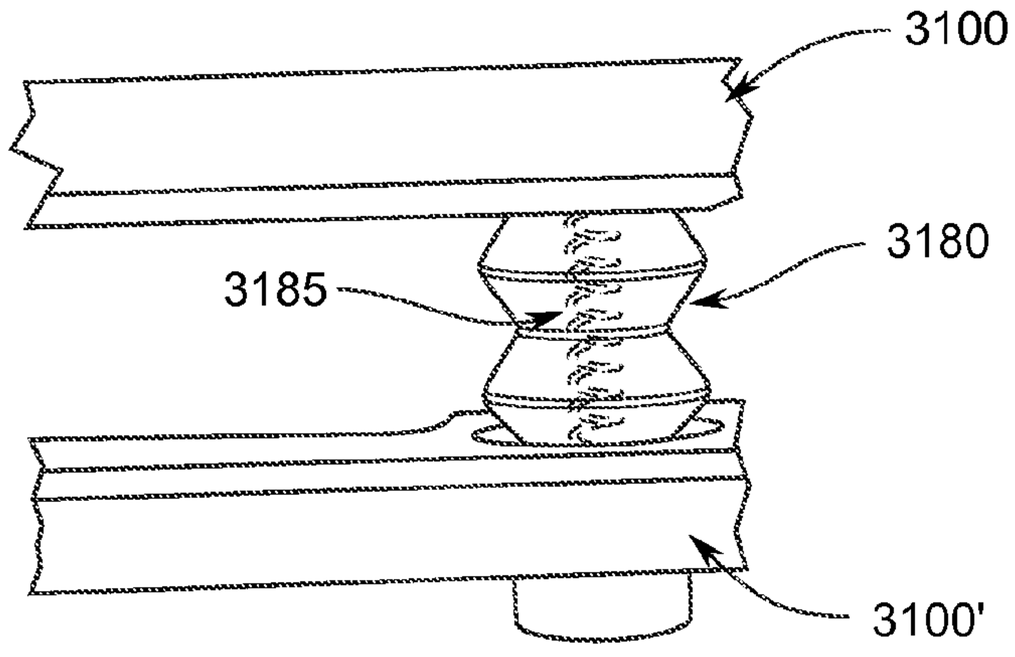

FIG. 46C

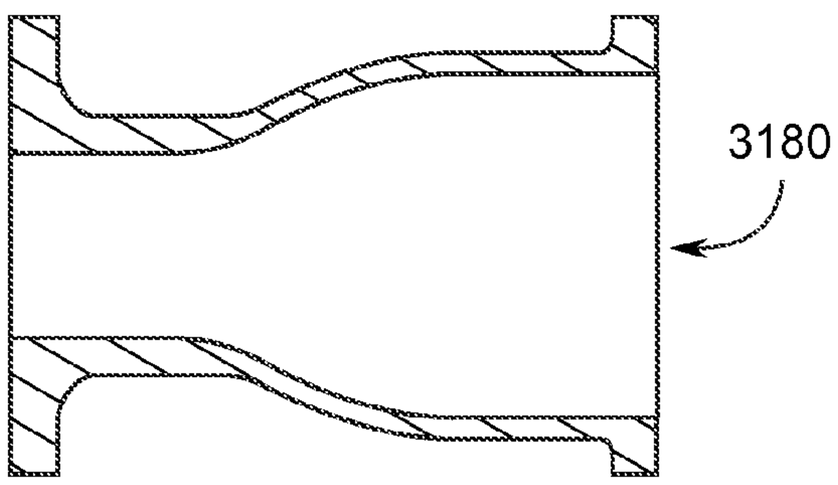

FIG. 46D

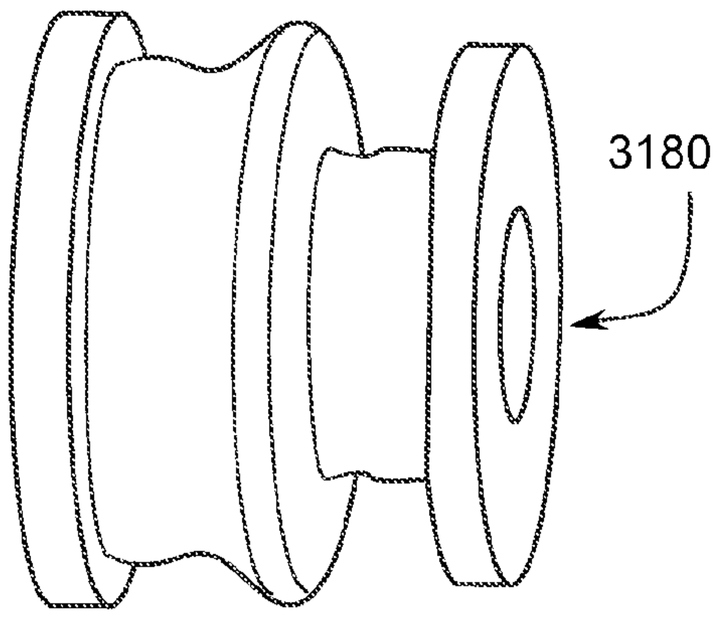

FIG. 46E

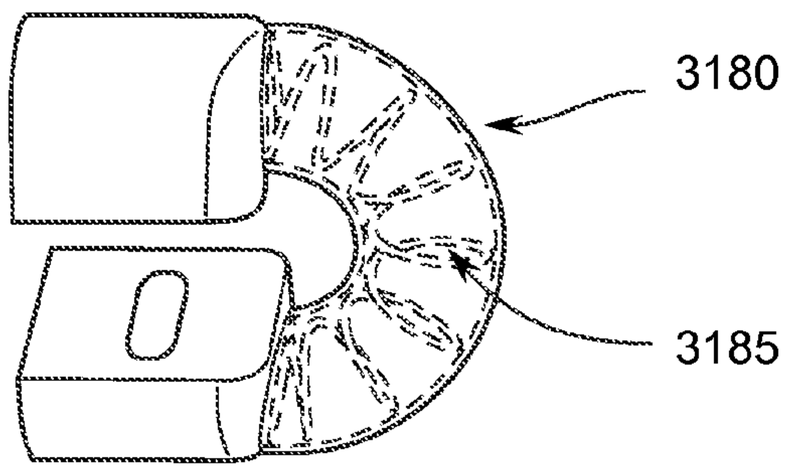

FIG. 46F

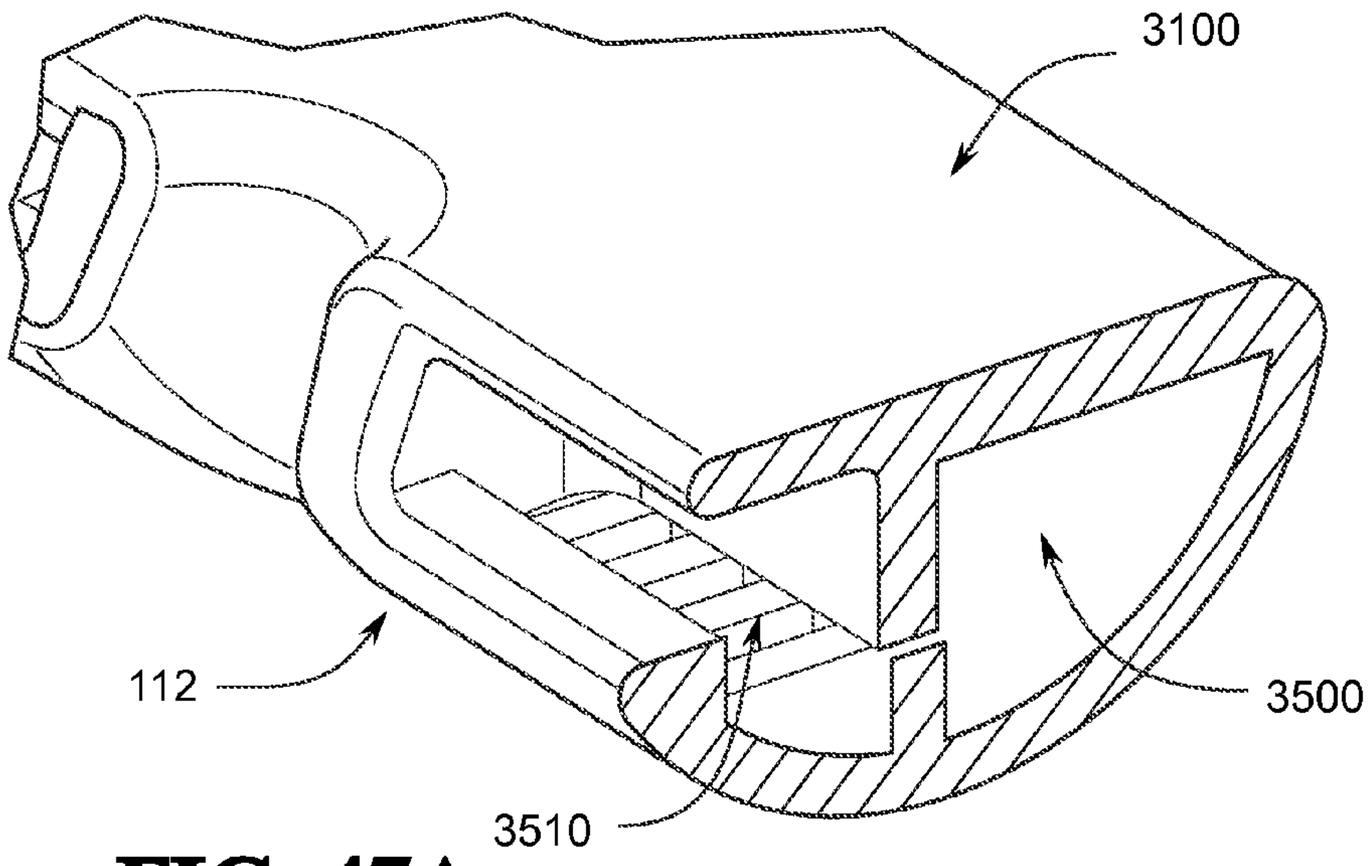

FIG. 47A

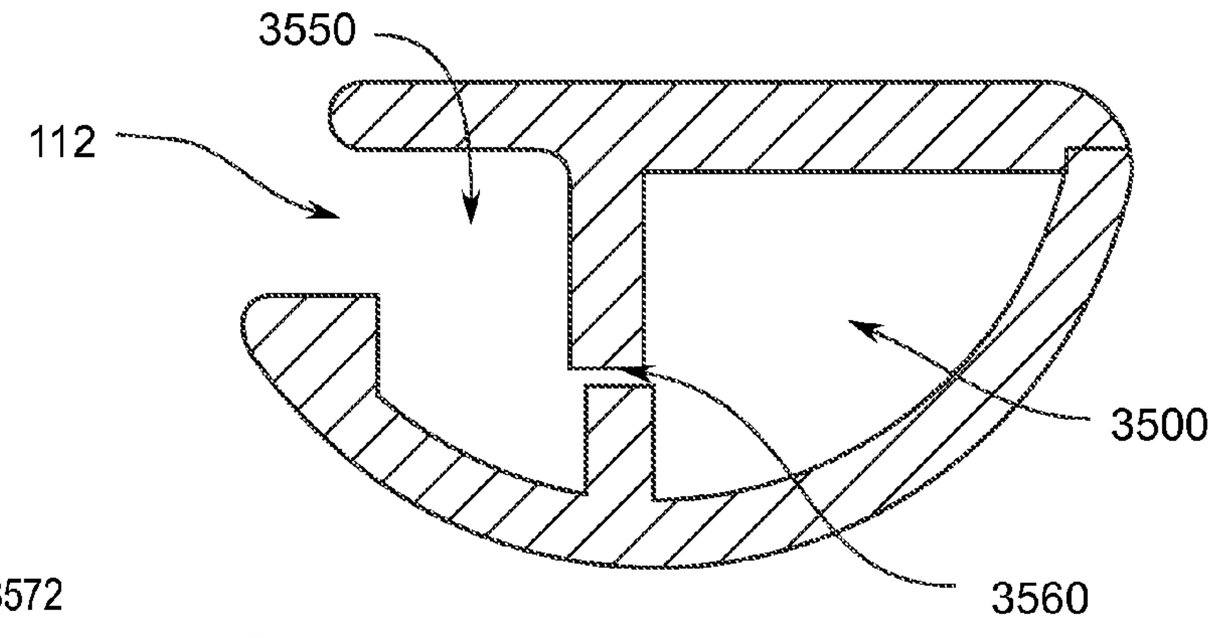

FIG. 47B

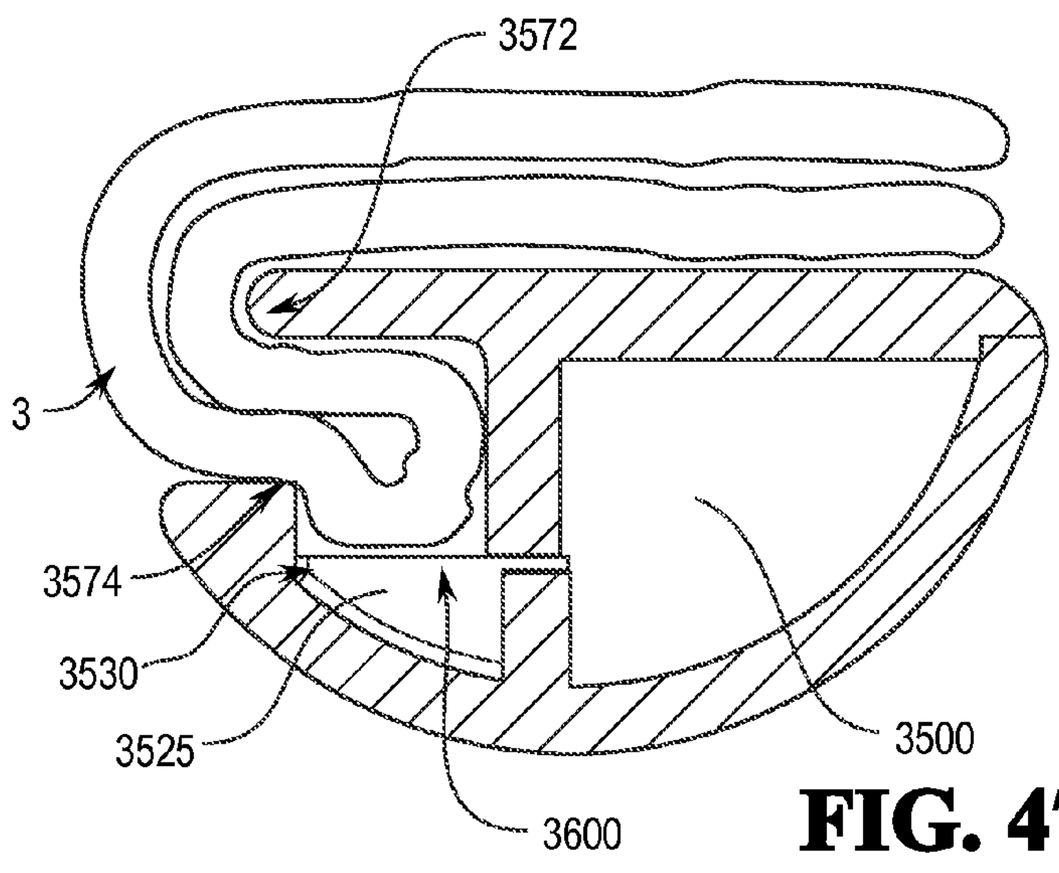

FIG. 47C

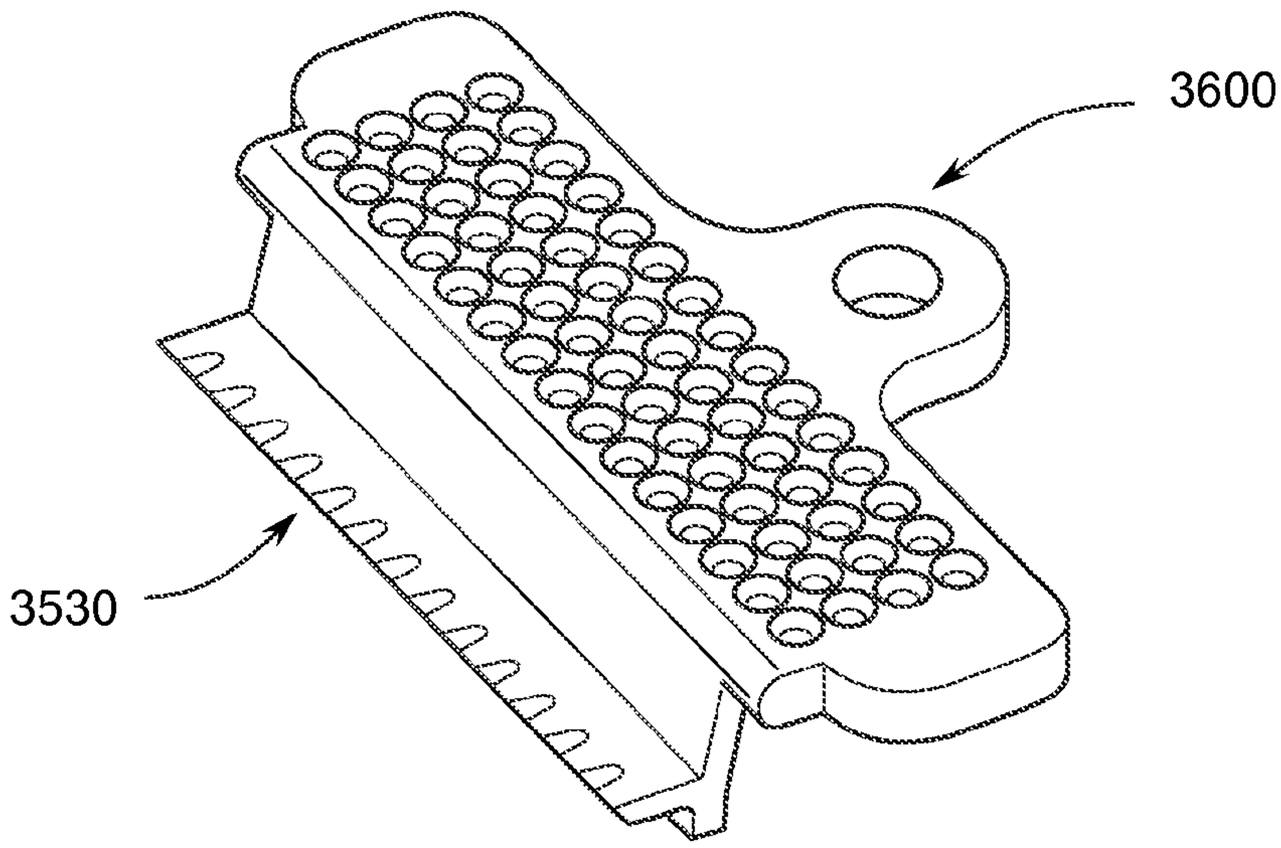

FIG. 47D

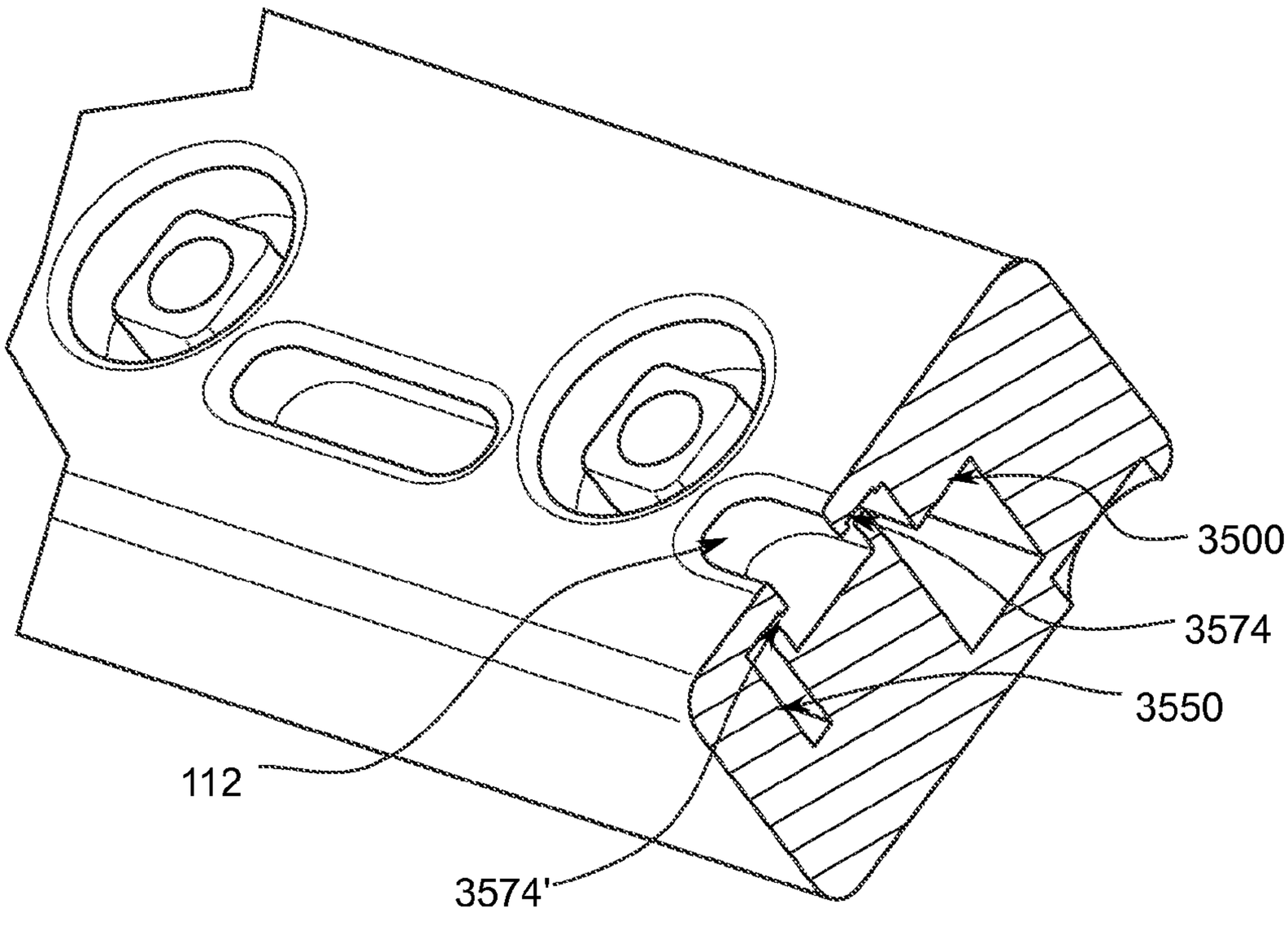

FIG. 47E

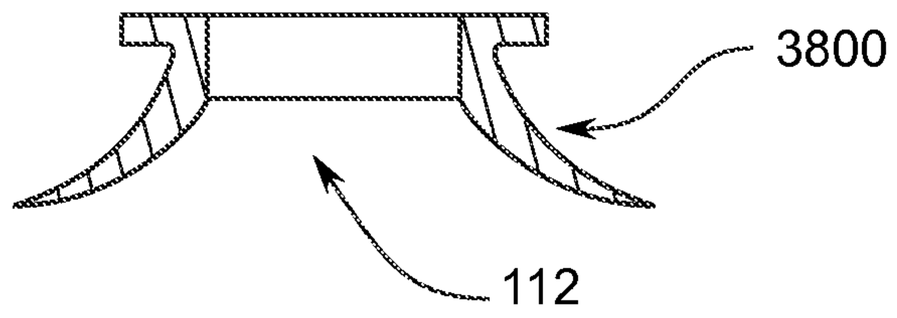

FIG. 47F

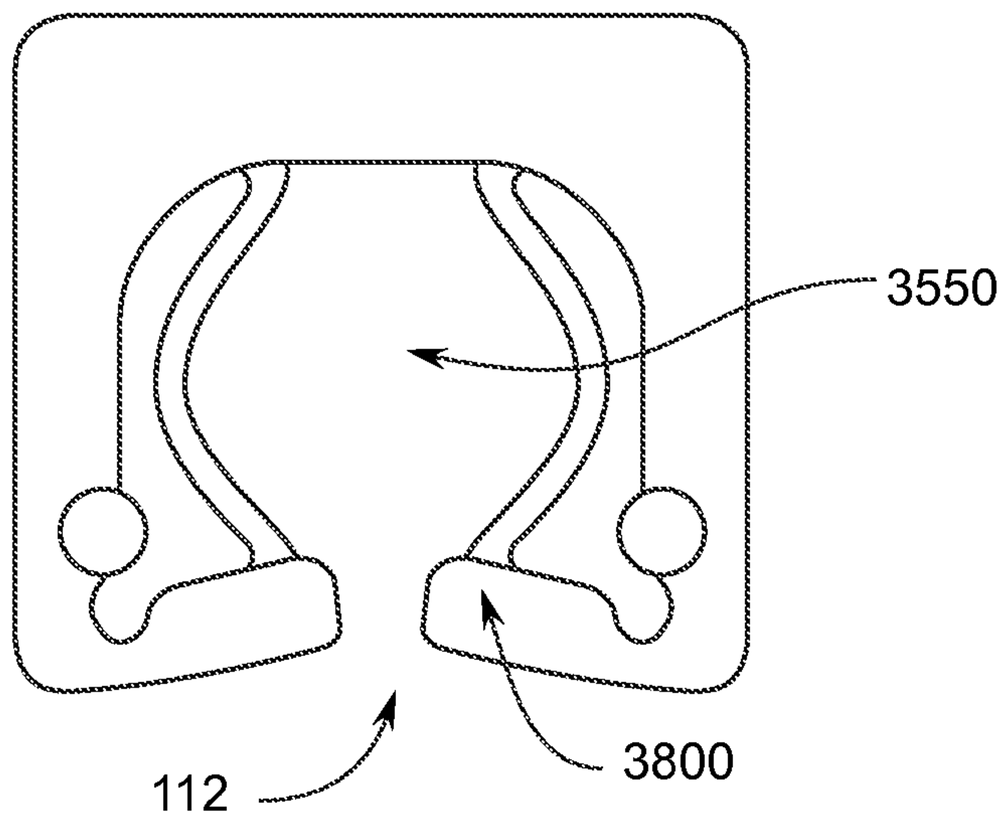

FIG. 47G

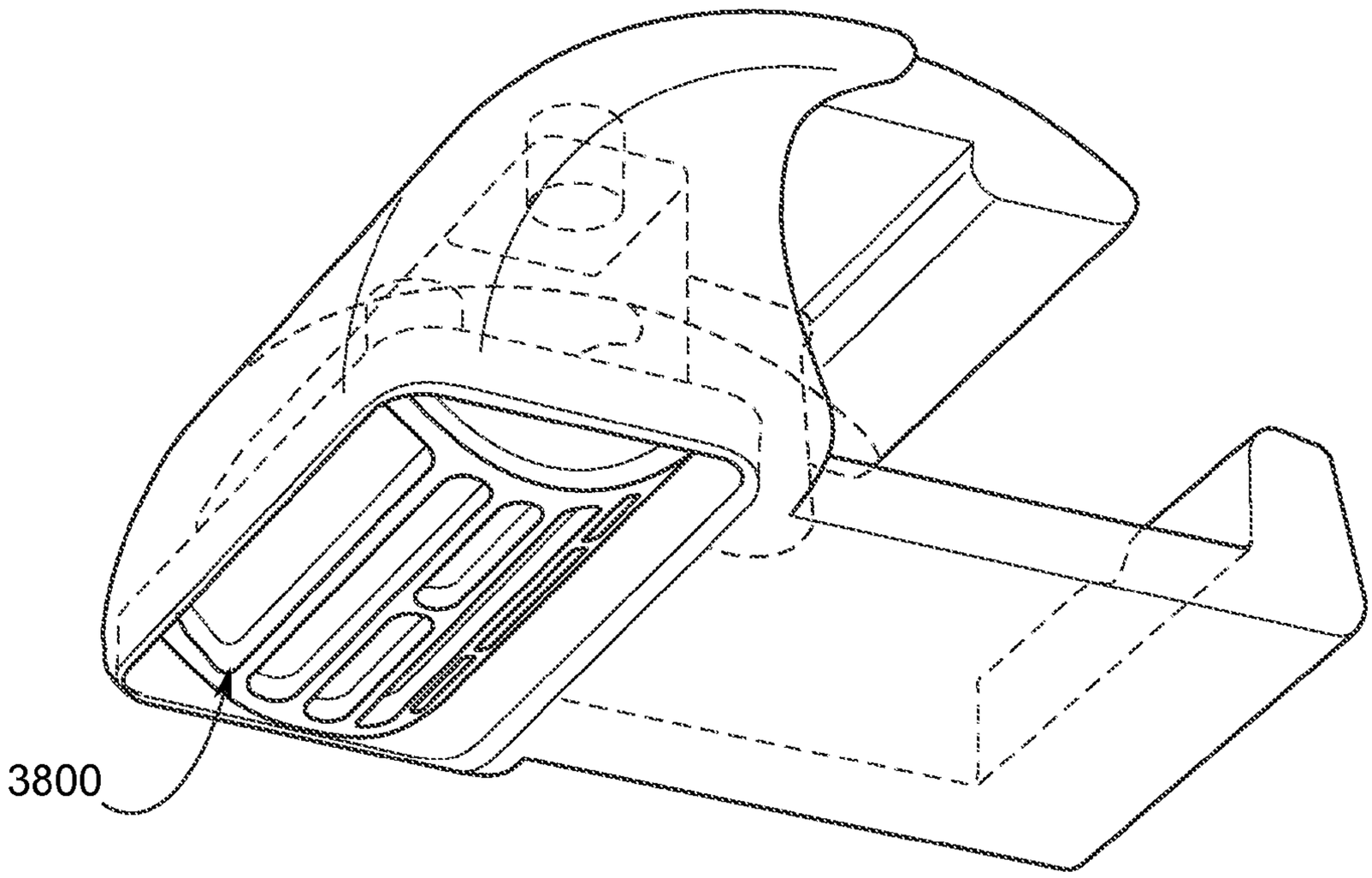

FIG. 47H

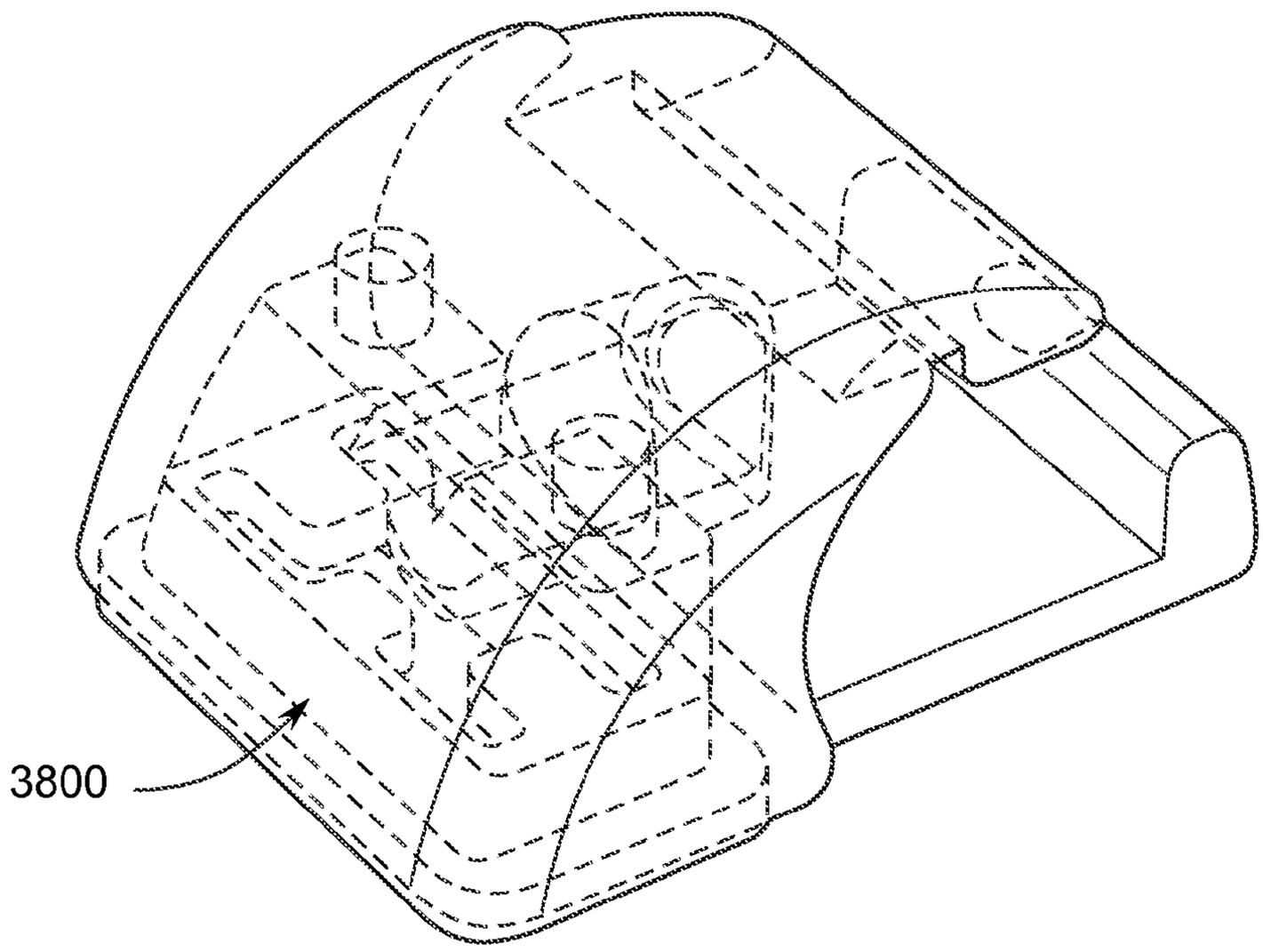

FIG. 47I

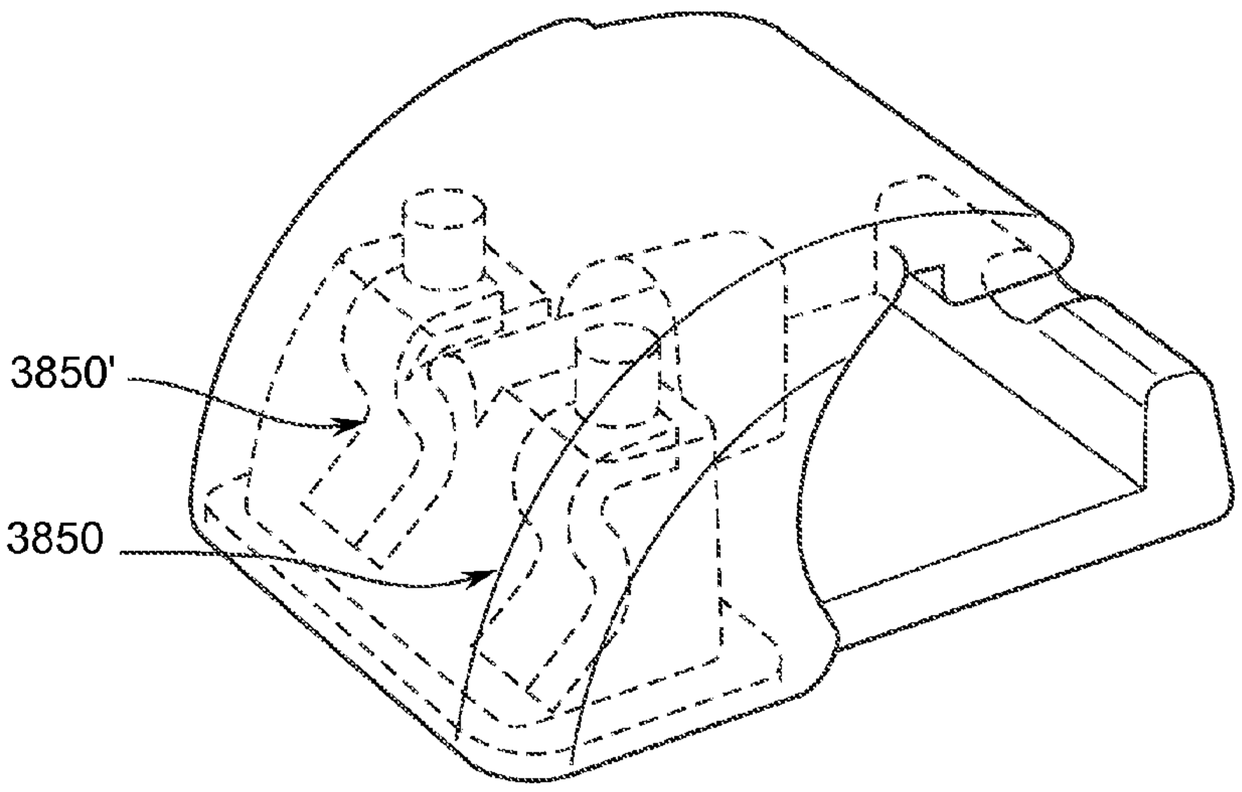

FIG. 47J

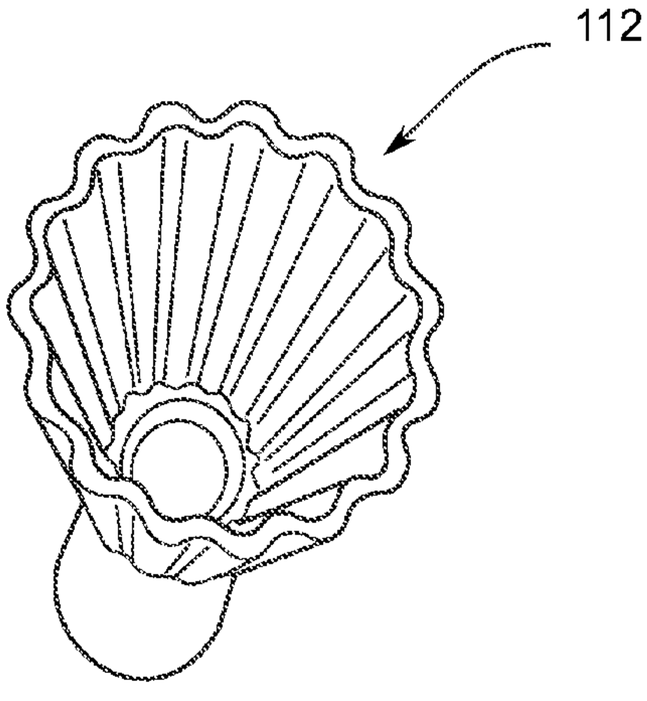

FIG. 47K

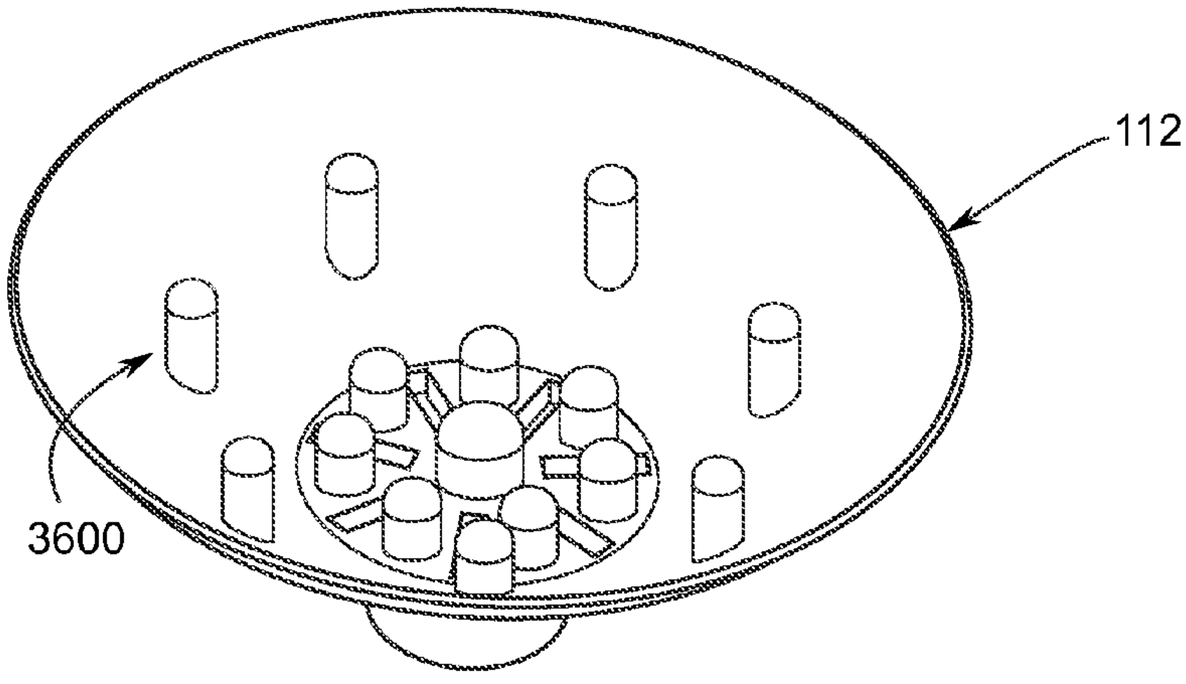

FIG. 47L

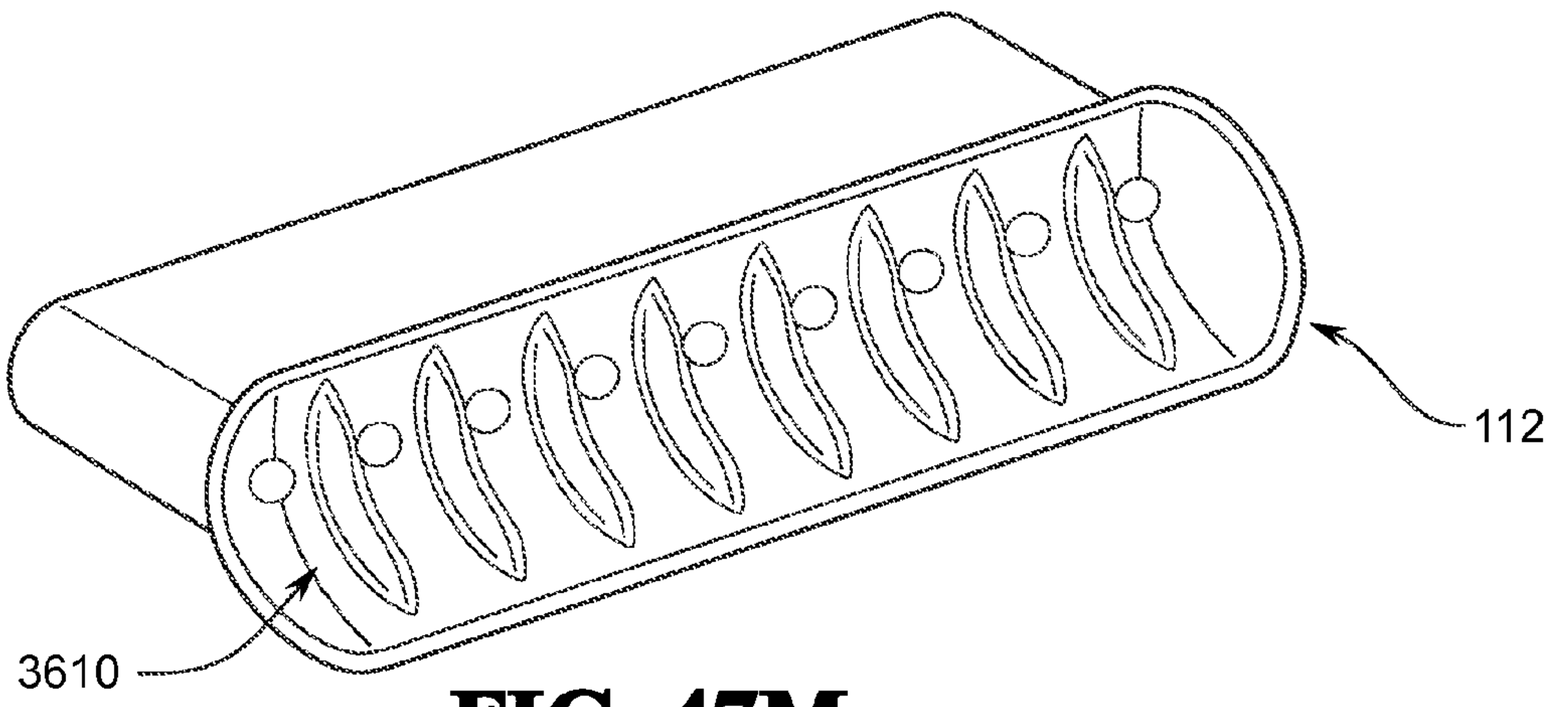

FIG. 47M

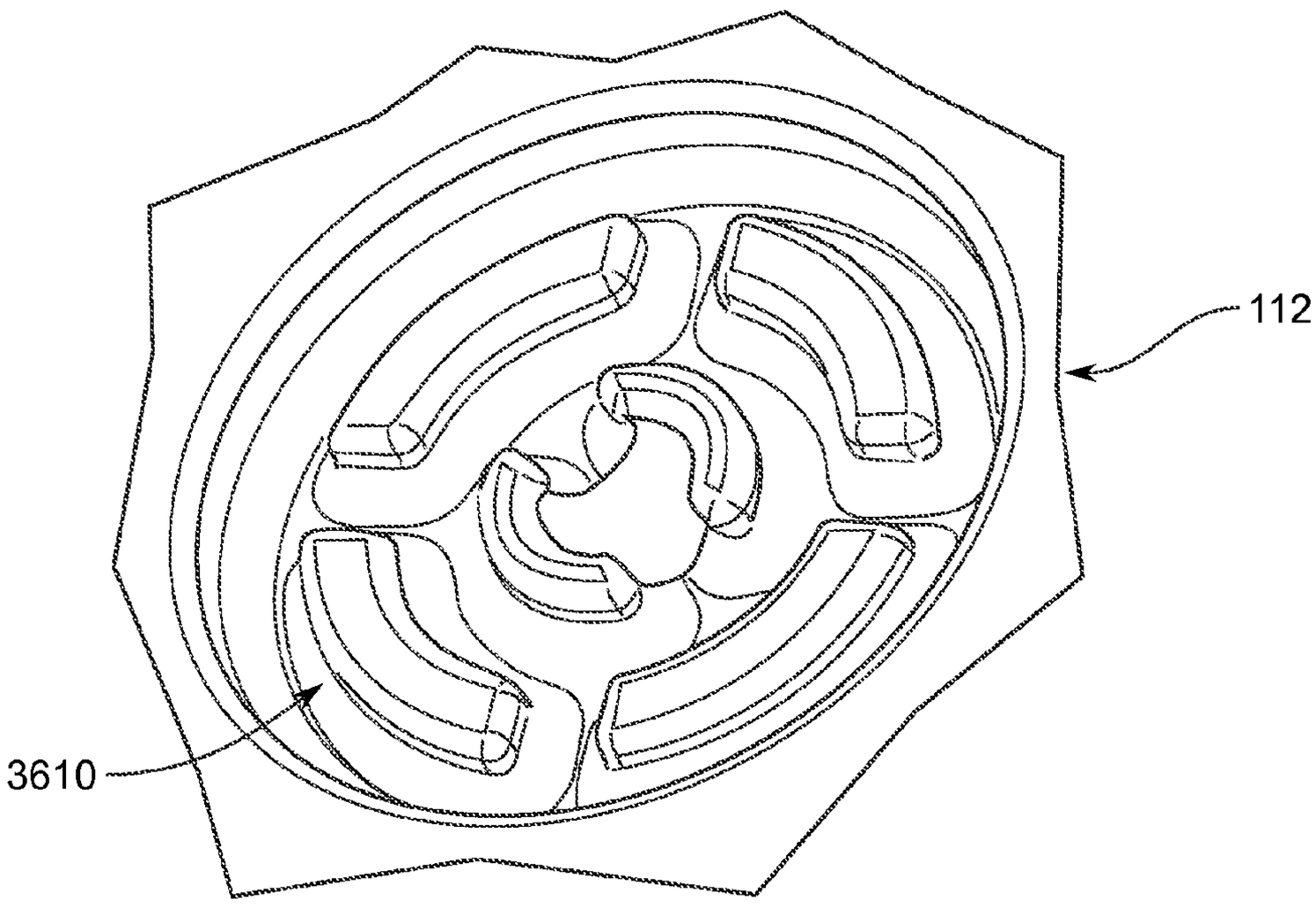

FIG. 47N

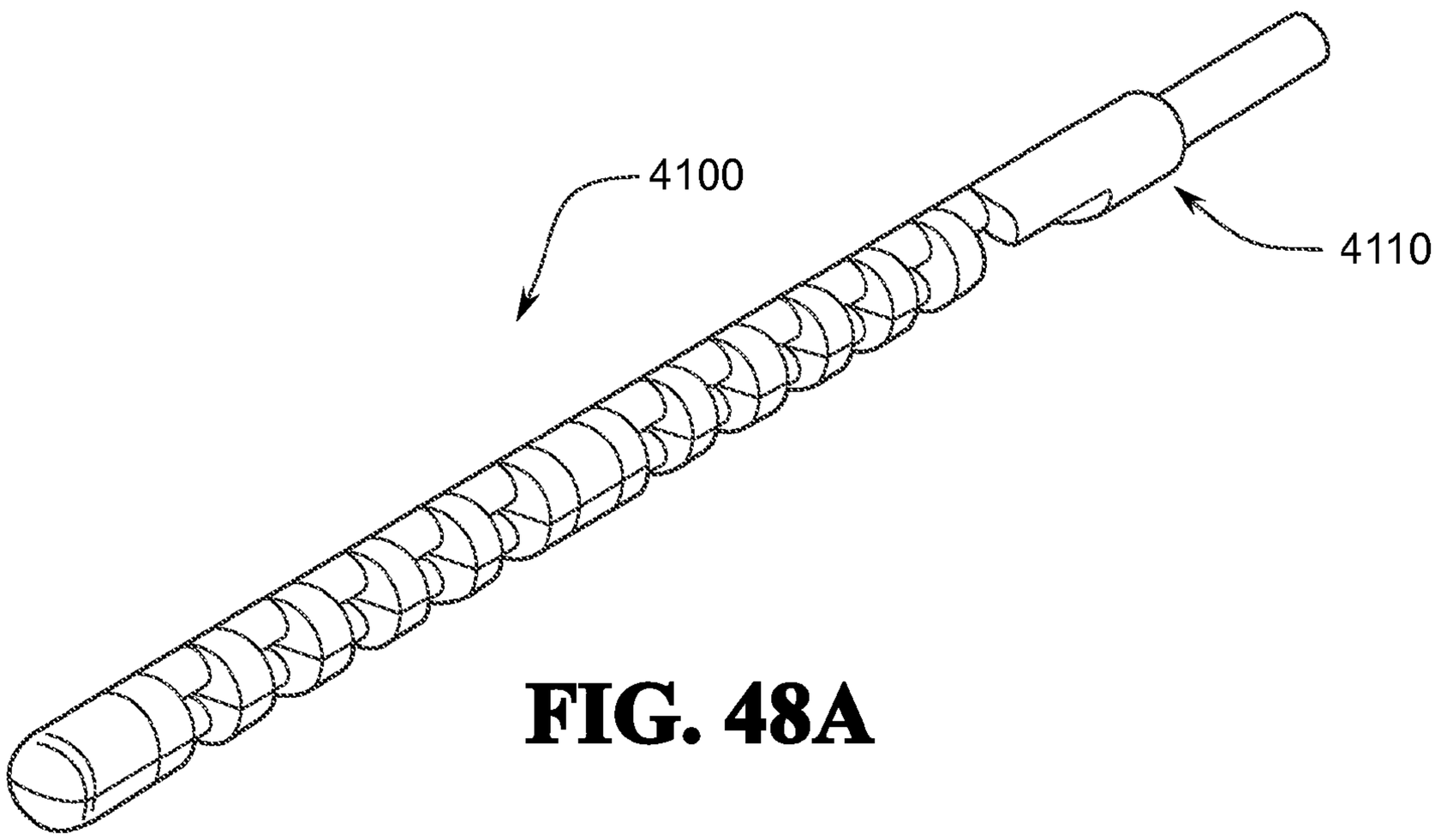

FIG. 48A

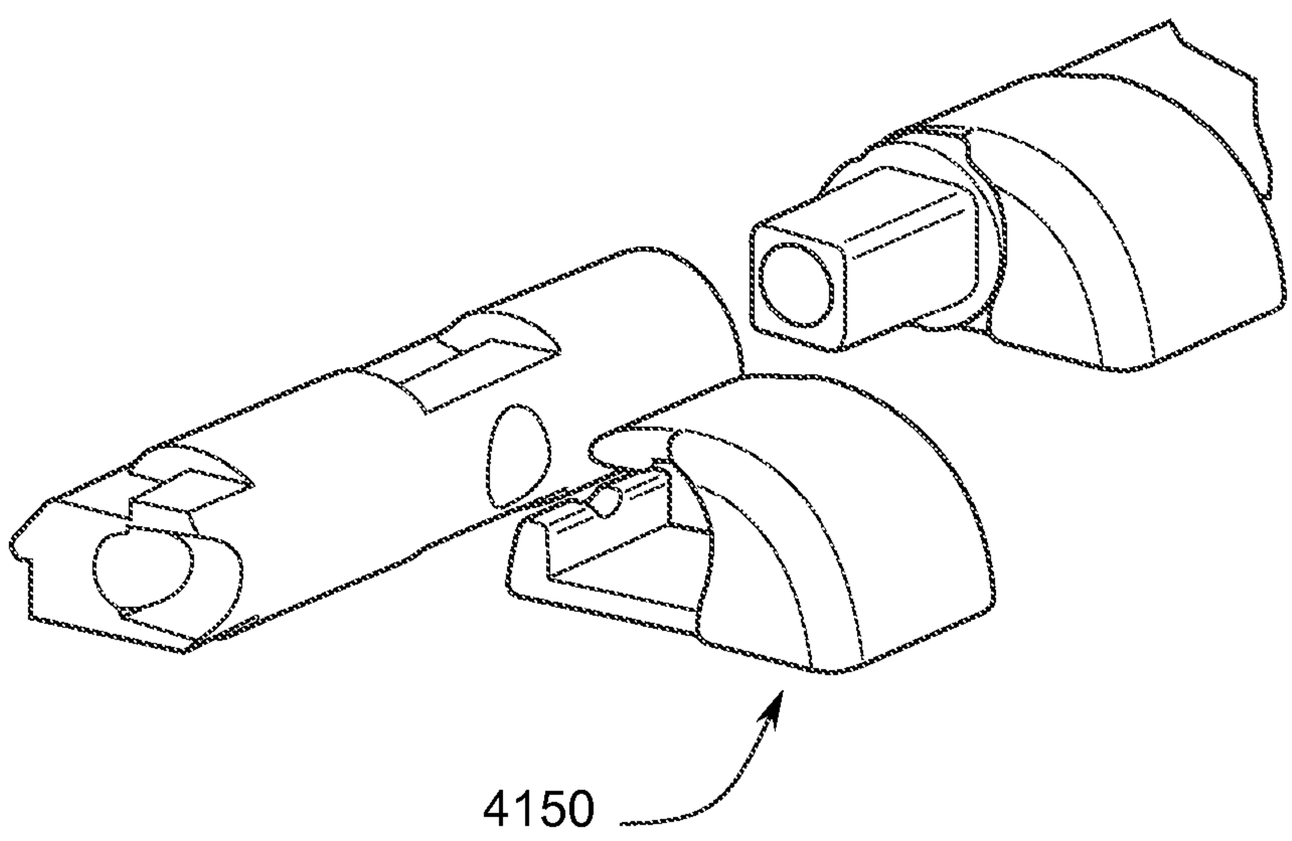

FIG. 48B

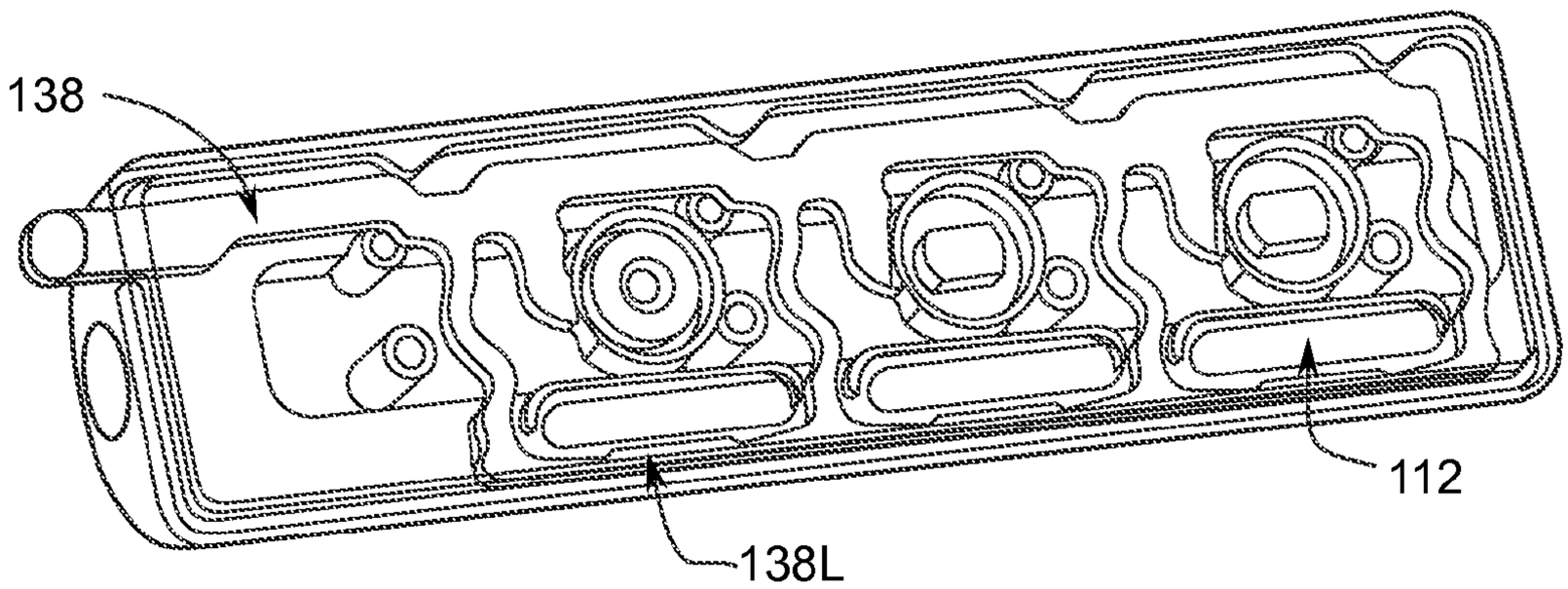

FIG. 49A

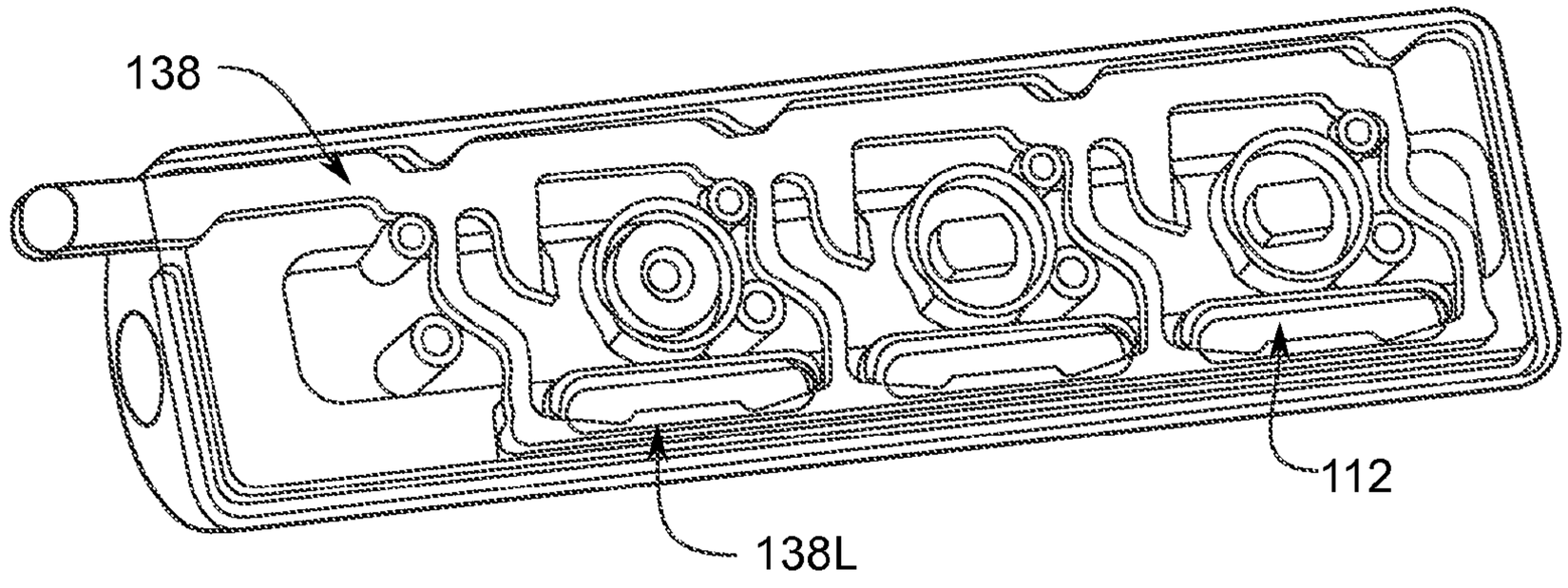

FIG. 49B

METHODS, INSTRUMENTS AND DEVICES FOR EXTRAGASTRIC REDUCTION OF STOMACH VOLUME

CROSS-REFERENCE

This application claims the benefit of U.S. Provisional Application No. 61/584,289, filed Jan. 8, 2012 and titled "Methods, Instruments and Devices for Extragastric Reduction of Stomach Tissue" and is a continuation-in-part of U.S. patent application Ser. No. 13/439,059, filed Apr. 4, 2012 and titled "Methods, Instruments and Devices for Extragastric Reduction of Stomach Volume," now U.S. Pat. No. 8,382,775, which applications are hereby incorporated herein, in their entirety, by reference thereto.

BACKGROUND OF THE INVENTION

Obesity has become a major health concern, both nationally and internationally. The National Center for Health Statistics (NCHS) estimates that over 120 million Americans are overweight, including about 56% of the adult population. Of these, about 52 million are considered obese, as measured by a body mass index (BMI) of 30% or greater. In Europe, an estimated 77 million people are obese, as measured by the same standard. This problem is not limited to western nations, as many developing countries are reported to have obesity rates over 75% of the adult population.

Co-morbidities that are associated with obesity include, but are not limited to type II Diabetes, high blood pressure, sleep apnea, stroke and arthritis, the symptoms of which often tend to be lessened or alleviated upon loss of weight by a person so affected.

One current treatment methodology for treatment of obesity is called gastric bypass surgery and another is referred to as gastric banding (one of these techniques uses a device referred to as the LAPBAND™). These procedures are limited to only those patients with a BMI over 40 (or over 35, with co-morbidities present).

Gastric bypass procedures incur a great deal of morbidity and create a malabsorptive state in the patient by bypassing a large portion of the intestines. Serious side effects, such as liver failure have been associated with this procedure, as well as chronic diarrhea. Another surgical procedure that has a high degree of morbidity associated with it is known as the "Gastric Bypass Roux-en-Y" procedure. This procedure reduces the capacity of the stomach by creating a smaller stomach pouch. The small space holds only about one ounce of fluid. A tiny stomach outlet is also surgically created to slow the speed at which food leaves the stomach. Staples are used to create a small (15 to 20 cc) stomach pouch, with the rest of the stomach being stapled completely shut and divided from the stomach pouch. The small intestine is divided just beyond the duodenum, brought up, and connected to the newly formed stomach pouch. In addition to the considerable morbidity associated with this procedure, other disadvantages include "dumping syndrome", where stomach contents are literally "dumped" rapidly into the small intestine which may lead to nausea, weakness, sweating, faintness, and diarrhea; hernias resulting from the surgery; gallstones; leakage of the connection between the pouch and the intestine; stretching of the pouch that was formed; nutritional deficiencies; and adverse effects, including but not limited to erosion of the mucosa caused by stapling entirely through the walls of the stomach.

The LAPBAND™ is a band that, when placed, encircles the fundus-cardia junction and is inflatable to constrict the same. It does not reduce the volume of the stomach, but rather restricts passage of food into the stomach, the theory being that the patient will feel satiety with a much less volume of food than previously. Although the LAPBAND™ procedure is less invasive than a gastric bypass procedure, it also typically achieves less weight loss. Further, it is not a simple procedure and requires a substantial amount of training by a surgeon to become proficient in performing the procedure. Also, a substantial amount of dissecting and suturing is required because the pathway by which the band is introduced is not an existing pathway, and must be established by dissection. Great care is required to avoid blood vessels and nerves that may be in the intended pathway to be created by the dissection. Another potential problem is that of slipping or other displacement of the band from its intended location which often requires another procedure to reposition, replace or altogether remove the band. After placing the band around the fundus-cardia junction, the ends of the band must be connected together and then it must be cinched down into place. Additionally, complications such as erosion at the fundus-cardia junction, slippage of the band from its intended location, nausea/vomiting, gastroesophageal reflux, dysphagia and lack of effectiveness in causing weight loss have been reported.

Intra-gastric balloons have also been placed, in an attempt to fill a portion of the volume in the stomach, with the theory being that it will then require less food than previously, to give the patient a sensation of fullness or satiety. This procedure involves delivery of a balloon (typically, trans-orally) to the interior of the stomach and inflation of the balloon to take up a portion of the volume inside the stomach. However, intragastric balloons may also lead to complications such as obstruction, vomiting and/or mucosal erosion of the inner lining of the stomach. The balloon can break down over extended exposure to the stomach's acids, and in some cases, after breaking down, the balloon translated through the intestines and caused a bowel obstruction.

Gastrointestinal sleeves have been implanted to line the stomach and/or a portion of the small intestines to reduce the absorptive capabilities of the small intestine and/or to reduce the volume in the stomach, by reducing the available volume to the tubular structure of the graft running therethrough. Although weight loss may be effective while these types of devices are properly functioning, there are complications with anchoring the device within the stomach/GI tract, as the stomach and GI tract function to break down things that enter into them and to move/transport them through. Accordingly, the integrity of the anchoring of the device, as well as the device itself may be compromised over time by the acids and actions of the stomach and GI tract.

A sleeve gastrectomy is an operation in which the left side of the stomach is surgically removed. This results in a much reduced stomach which is substantially tubular and may take on the shape of a banana. This procedure is associated with a high degree of morbidity, as a large portion of the stomach is surgically removed. Additionally, there are risks of complications such as dehiscence of the staple line where the staples are installed to close the surgical incisions where the portion of the stomach was removed. Further, the procedure is not reversible.

In the laparoscopic duodenal switch, the size of the stomach is reduced in similar manner to that performed in a sleeve gastrectomy. Additionally, approximately half of the small intestine is bypassed and the stomach is re-connected to the shortened small intestine. This procedure suffers from the same complications as the sleeve gastrectomy, and even greater morbidity is associated with this procedure due to the

additional intestinal bypass that needs to be performed. Still further, complications associated with malabsorption may also present themselves.

An inflatable gastric device is disclosed in U.S. Pat. No. 4,246,893, in which a balloon is inserted anteriorly of the stomach and posteriorly of the left lobe of the liver. The balloon is then inflated to compress the stomach so that it fills with less food that would ordinarily be possible. Not only does this device compress the stomach, but it also compresses the liver, as seen in FIG. 5 of the patent, which may cause complications with the liver function. Additionally, the balloon is simply placed into this location, and there is no assurance that it will not migrate and lose its effectiveness in compressing the stomach to the degree intended. Still further, the balloon is of a simple spherical design, and, as such, extends pressure outwardly in all directions, 360 degrees in all planes. Accordingly, the liver is compressed just as much as the stomach is. Also, the compression forces against the stomach are not ideal, as the spherical balloon conformation does not match the conformation of the expanding stomach. The stomach is not spherical when expanded, or concave with a constant radius of curvature, but expands into a designated space that allows the fundus to expand preferentially more than other parts of the stomach.

U.S. Pat. No. 7,717,843 and U.S. Patent Application Publication No. 2005/0261712 to Balbierz et al. describe capturing a device against the outer surface of the stomach wall to form a restriction that appears to function similarly to the restriction imposed by the LAPBAND™. The anchoring of the devices disclosed relies upon placement of features against the internal wall of the stomach to form an interlock with the device which is placed against the external wall of the stomach. The placement of features against the internal wall runs the risk of erosion of the mucosa, digestion and/or displacement of the features against the internal wall, and other risks associated with implanting within the stomach, as described above.

U.S. Pat. No. 6,981,978 to Gannoe discloses devices for reducing the internal cavity of the stomach to a much smaller volume, which may be used to carry out a bypass procedure. Stapling is employed to isolate the smaller volume in the stomach, and thus the same potential disadvantages are present as with other stapling procedures used to staple the stomach together in mucosa to mucosa contact as described herein.

U.S. Pat. No. 6,186,149 to Pacella et al. describes an occluder device that can be used as a dietary control device (see FIG. **8**C). The occluder device is placed against the wall of the stomach and inflated to press inwardly on the stomach wall. A frame is wrapped around the stomach wall and is inflated to press against the stomach wall. However, there is no disclosure of how the frame might be adjusted to maintain a position relative to the stomach wall as the size of the stomach varies.

Gastric reduction techniques have been attempted, such as by inserting instruments trans-orally and reducing the volume of the stomach by stapling portions of it together. However, this technique also runs risks such as those described above, such as erosion of the mucosa.

Techniques referred to as gastric pacing endeavor to use electrical stimulation to simulate the normal feedback mechanisms of a patient that signal the brain that the patient is full, or satiated. While these techniques are less invasive than some of the other existing treatments, statistics to date have shown that the amount of weight lost by using such techniques is less than satisfactory.

Currently marketed drugs for weight loss, such as XENICAL®, MERIDIA® and Phen fen have largely failed, due to unacceptable side effects and complications, and sometimes to an ineffective amount of weight loss. Other drugs that are on the horizon include ACCOMPLIA® and SYMLIN®, but these are, as yet, unproven.

The risk and invasiveness factors of currently available surgeries are often too great for a patient to accept to undergo surgical treatment for his/her obesity. Accordingly, there is a need for less invasive, yet effective surgical treatment procedures for morbidly obese patients (patients having a BMI of 35 or greater). Also, since the current surgical procedures are currently indicated only for those patients having a BMI of 40 or greater, or 35 or greater when co-morbidities are present, it would be desirable to provide a surgical procedure that would be available for slightly less obese patients, e.g., patients having a BMI of 30 to 35 who are not indicated for the currently available surgical procedures. It would further be desirable to provide a surgical procedure that would be indicated for obese patients having a BMI in the range of 30-35, as well as for more obese patients.

SUMMARY OF THE INVENTION

According to one aspect of the present invention, a method for decreasing the effective volume of a patient's stomach is provided that includes: contacting and engaging a length of a first end effector to an external surface of the stomach on a first side of the stomach; contacting and engaging a length of a second end effector to an external surface of the stomach on a second side of the stomach opposite the first side; separating the first and second end effectors and opposite sides of the stomach; moving a portion of the stomach through a gap formed by separating the first and second end effectors; and moving the first and second end effectors and the opposite sides of the stomach toward one another to contact folded tissue surfaces adjacent the surfaces engaged by the end effectors into contact with one another.

In at least one embodiment, the method includes attaching the folded tissue surfaces together in serosa-to-serosa contact.

In at least one embodiment, the method includes rotating the first and second end effectors to rotate the stomach so that the portion of the stomach is superior to the gap; wherein moving a portion of the stomach through a gap is assisted by gravity as the portion is dropped through the gap between the first and second end effectors.

In at least one embodiment, the method includes counter-rotating the end effectors after moving the first and second end effectors toward one another to contact folded tissue surfaces adjacent the surfaces engaged by the end effectors into contact with one another.

In at least one embodiment, the rotating comprises rotating by about ninety degrees.

In at least one embodiment, the counter-rotating is an amount about equal to the rotation.

In at least one embodiment, the engaging is performed by applying suction to the surfaces through the end effectors.

In at least one embodiment, the first and second end effectors are distal end portions of a clamping tool.

In at least one embodiment, attaching the folded tissue surfaces together comprises driving sutures from one of the end effectors through the folded tissues and into connection with anchors on the other of the end effectors.

In at least one embodiment, the method includes placing a layer of material adjacent to or between a location where the folded tissues are connected together to discourage the stomach from herniating out between suture connections.

In at least one embodiment, the layer of material discourages ingrowth of tissue therein.

In at least one embodiment, the method includes temporarily installing a bougie in the stomach prior to moving a portion of the stomach, to provide a guide for the resulting size of the lumen through the stomach.

In at least one embodiment, at least a portion of the bougie has clear walls and the bougie is configured to receive a flexible endoscope therein, the method further comprising inserting the flexible endoscope and visualizing within the stomach through the bougie.

In at least one embodiment, the method includes inserting an expandable implant in a plication formed by moving a portion of the stomach through a gap formed by separating the first and second end effectors; and wherein moving the first and second end effectors toward one another to contact folded tissue surfaces adjacent the surfaces engaged by the end effectors into contact with one another surrounds the expandable implant.

In at least one embodiment, the method includes placing a layer of material adjacent to or between a location where the folded tissues are connected together to discourage the stomach from herniating out between connections.

In at least one embodiment, the layer of material extends from and is connected to or integral with the expandable implant.

In at least one embodiment, the layer of material discourages ingrowth of tissue therein.

In at least one embodiment, attaching the folded tissue surfaces together in serosa-to-serosa contact comprises simultaneously driving a plurality of attachment members through the folded tissue surfaces, wherein the attachment members are configured along a length direction relative to the end effectors.

In another aspect of the present invention, an instrument for use in modifying a patient's stomach by operating on the stomach extragastric ally to decrease the effective volume of the patient's stomach is provided that includes: a first elongate end effector at a distal end portion of the instrument, the first elongate end effector having a first operational surface configured to contact an external surface of the patient's stomach; a second elongate end effector at a distal end portion of the instrument, the second elongate end effector having a second operational surface configured to contact an external surface of the patient's stomach on a location opposite of where the first elongate end effector is configured to contact the external surface of the stomach, and wherein the second operational surface opposes the first operational surface; a first plurality of suction ports extending along a length of the first elongate end effector and configured to deliver suction to the external surface of the stomach to engage the first elongate end effector therewith; and a second plurality of suction ports extending along a length of the second elongate end effector and configured to deliver suction to the external surface of the stomach to engage the second elongate end effector therewith.

In at least one embodiment, the first and second pluralities of suction ports are configured to apply suction in an amount sufficient to pull opposite walls of the stomach apart when the first and second elongate end effectors are engaged therewith and the first and second elongate end effectors are moved apart from one another, and wherein the opposite walls are pulled apart without losing engagement of the first and second elongate end effectors therewith.

In at least one embodiment, the first elongate end effector has a first distal end portion and a first proximal end portion and the second elongate end effector has a second distal end portion and a second proximal end portion, wherein the first and second elongate end effectors are pivotally connected at the first and second proximal end portions, and wherein the first and second distal end portions include first and second free distal ends, respectively.

In at least one embodiment, the instrument further includes means for driving a plurality of connectors from the first elongate end effector, through stomach tissue and to the second elongate end effector.

In at least one embodiment, the instrument further includes means for fixing the connectors to maintain a plication in the stomach.

In at least one embodiment, the suction ports are elongated.

In at least one embodiment, the instrument further includes an elongate shaft extending proximally from proximal end portions of the first and second elongate members.

In at least one embodiment, the instrument further includes an actuator located on a handle at a proximal end portion of the elongate shaft, the actuator being configured to actuate at least one function of the elongate end effectors.

In at least one embodiment, the instrument further includes a plurality of suture drivers extending along a length of the first elongate end effector.

In at least one embodiment, the instrument further includes a plurality of suture anchors extending along a length of the second elongate end effector and opposing the plurality of suture drivers, respectively.

In at least one embodiment, the instrument further includes a plurality of sutures releasably engaged with the plurality of suture drivers, respectively.

In at least one embodiment, each suture extends through a suture lock releasably provided on the first elongate end effector.

In at least one embodiment, each suture comprises an anchor mate mounted on a distal end portion thereof, the anchor mate being configured to engage with and connect to the anchor.

In at least one embodiment, the instrument is further provided with a layer of material configured to be placed adjacent to or between locations where the connectors from the first elongate end effector are configured to pass through the stomach tissue and to the second elongate end effector.

In at least one embodiment, the layer of material discourages ingrowth of tissue therein.

In at least one embodiment, an expandable implant is provided that is configured to be implanted in a plication created by the instrument.

In at least one embodiment, a bougie is provided that is configured to be temporarily placed in the stomach prior to forming a plication with the instrument.

In at least one embodiment, at least a portion of the bougie has clear walls and the bougie is configured to receive a flexible endoscope therein.

In at least one embodiment, a flexible endoscope is provided that is insertable into the bougie.

In another aspect of the present invention, a system for use in modifying a patient's stomach by operating on the stomach extragastric ally to decrease the effective volume of the patient's stomach is provided that includes: an engagement instrument comprising: a first elongate end effector at a distal end portion of the engagement instrument, the first elongate end effector having a first operational surface configured to contact an external surface of the patient's stomach; a second elongate end effector at a distal end portion of the engagement instrument, the second elongate end effector having a second operational surface configured to contact an external surface of the patient's stomach on a location opposite of where the

first elongate end effector is configured to contact the external surface of the stomach, and wherein the second operational surface opposes the first operational surface; a first plurality of suction ports extending along a length of the first elongate end effector and configured to deliver suction to the external surface of the stomach to engage the first elongate end effector therewith; and a second plurality of suction ports extending along a length of the second elongate end effector and configured to deliver suction to the external surface of the stomach to engage the second elongate end effector therewith; and a stitching instrument comprising: a third elongate end effector at a distal end portion of the stitching instrument, the third elongate end effector having a third operational surface configured to contact an external surface of the patient's stomach; a fourth elongate end effector at a distal end portion of the stitching instrument, the fourth elongate end effector having a fourth operational surface configured to contact an external surface of the patient's stomach on a location opposite of where the third elongate end effector is configured to contact the external surface of the stomach, and wherein the fourth operational surface opposes the third operational surface; a plurality of suture drivers extending along a length of the third elongate end effector; and a plurality of suture anchors extending along a length of the fourth elongate end effector and opposing the plurality of suture drivers, respectively.

In at least one embodiment, the first and second pluralities of suction ports are configured to apply suction in an amount sufficient to pull opposite walls of the stomach apart when the first and second elongate end effectors are engaged therewith and the first and second elongate end effectors are moved apart from one another, and wherein the opposite walls are pulled apart without losing engagement of the first and second elongate end effectors therewith.

In at least one embodiment, the first elongate end effector has a first distal end portion and a first proximal end portion and the second elongate end effector has a second distal end portion and a second proximal end portion, wherein the first and second elongate end effectors are pivotally connected at the first and second proximal end portions, and wherein the first and second distal end portions include first and second free distal ends, respectively.

In at least one embodiment, the suction ports are elongated.

In at least one embodiment, the system further includes an elongate shaft extending proximally from proximal end portions of the first and second elongate members.

In at least one embodiment, the system further includes an actuator located on a handle at a proximal end portion of the elongate shaft, the actuator being configured to actuate at least one function of the elongate end effectors.

In at least one embodiment, the system further includes a plurality of sutures releasably engaged with the plurality of suture drivers, respectively.

In at least one embodiment, each suture extends through a suture lock releasably provided on the third elongate end effector.

In at least one embodiment, each suture comprises an anchor mate mounted on a distal end portion thereof, the anchor mate being configured to engage with and connect to the anchor.

In at least one embodiment, the system further includes a layer of material configured to be placed adjacent to or between locations where the suture drivers from the third elongate end effector are configured to pass through the stomach tissue and to the suture anchors on the fourth elongate end effector.

In at least one embodiment, the layer of material discourages ingrowth of tissue therein.

In at least one embodiment, the system further includes expandable implant attached to or integral with the layer of material and configured to be implanted in a plication created by the instruments.

In at least one embodiment, the system further includes an expandable implant configured to be implanted in a plication created by the instruments.

In at least one embodiment, the system further includes a bougie configured to be temporarily placed in the stomach prior to forming a plication with the instruments.

In another aspect of the present invention, a method for decreasing the effective volume of a patient's stomach is provided that includes: contacting a length of an end effector to an external surface of the stomach; forming a fold in the stomach and positioning the fold over a portion of the end effector; and simultaneously driving a plurality of attachment members through the fold, wherein the attachment members are configured along a length direction relative to the end effector.

In at least one embodiment, forming a fold in the stomach comprises forming a pair of folds in the stomach, and wherein positioning the fold over a portion of the end effector comprises positioning each of the pair of folds over portions of the end effector on opposite sides of the end effector.

In at least one embodiment, the attachment members through the fold are located in the upper third of the stomach.

In at least one embodiment, the method further includes withdrawing the end effector while leaving the attachment members in place in the fold.

In at least one embodiment, the method further includes attaching a strip to the fold via the attachment members, wherein the strip is configured to encourage tissue ingrowth on a side of the strip that contacts the fold.

In at least one embodiment, a side of the strip opposite the side configured to encourage tissue ingrowth is configured to discourage tissue ingrowth.

In at least one embodiment, the method further includes installing a device between an external surface of the stomach and the fold using the end effector.

In at least one embodiment, the method further includes withdrawing the end effector and drawing down the attachment members to securely implant the device.

In at least one embodiment, the device is an expandable device, the method further comprising expanding the device to further reduce the effective volume of the stomach.

In at least one embodiment, the expandable device is fillable, and wherein the expanding is carried out by increasing an amount of fill in the device.

In at least one embodiment, the fill comprises a fluid.

In at least one embodiment, the pair of folds are positioned over the opposite sides of the end effector using a grasping device and are held in position by pushing the folds onto tissue pins on the end effector.

In at least one embodiment, the method further includes removing the end effector after driving the attachment members through the folds and tightening the attachment members to draw portions of the folds into serosa-to-serosa contact.

In at least one embodiment, the end effector engages tissue of the stomach and drives the tissue to perform the positioning of the fold.

In at least one embodiment, the end effector engages the tissue and drives the tissue to perform the forming of a fold.

In at least one embodiment, opposite side portions of the end effector engage tissue of the stomach and drive the tissue to perform the positioning of the folds.

In at least one embodiment, the opposite side portions of the end effector engage the tissue and drive the tissue to perform the forming a pair of folds.

In at least one embodiment, the method further includes: inserting a guide tool within the stomach; and aligning the length of the end effector with the stomach.

In another aspect of the present invention, a method for decreasing the effective volume of a patient's stomach is provided that includes: contacting a length of an end effector to an external surface of the stomach; forming a pair of folds in the stomach and positioning the folds over opposite side portions of the end effector; and connecting the folds to one another.

In at least one embodiment, the folds are connected in serosa-to-serosa contact.

In at least one embodiment, the method further includes removing the end effector after the connecting of the folds to one another.

In at least one embodiment, the method further includes overlaying a conjunction member on the folds to bridge the folds.

In at least one embodiment, the method further includes placing a device between an external surface of the stomach and the folds.

In at least one embodiment, the device is an expandable device, the method further comprising expanding the device to further reduce the effective volume of the stomach.

In at least one embodiment, the expandable device is fillable, and wherein the expanding is carried out by increasing an amount of fill in the device.

In at least one embodiment, the fill comprises a fluid.

In at least one embodiment, the method further includes: inserting a guide tool within the stomach; and aligning the length of the end effector with the stomach.

In another aspect of the present invention, a method for decreasing the effective volume of a patient's stomach is provided that includes: contacting an end effector carrying an implantable device to an external surface of the stomach; forming a pair of folds in the stomach and positioning the folds over opposite side portions of the end effector; and connecting the folds to one another.

In at least one embodiment, the method further includes removing the end effector while leaving the device in position between an external surface of the stomach and the pair of folds.

In at least one embodiment, the method further includes expanding the device to further reduce the effective volume of the stomach.

In another aspect of the present invention, an instrument for use in modifying a patient's stomach by operating on the stomach extragastrically is provided that includes: an elongate end effector at a distal end portion of the instrument, the end effector having a distal end, a proximal end and first and second sides; an elongate shaft extending proximally from the proximal end of the end effector, the shaft having sufficient length so that a proximal end of the shaft extends out of the patient's body when the end effector is placed on the patient's stomach; a plurality of piercing members extending lengthwise along the end effector; and a plurality of attachment members extending lengthwise along the end effector, the attachment members configured and positioned to be driven through a fold in the stomach.

In at least one embodiment, the instrument further includes an elongate strap configured and dimensioned to attach to the distal and proximal end of the end effector, to hold the fold in approximation to the end effector.

In at least one embodiment, the plurality of piercing members are arranged along both sides of the end effector.

In at least one embodiment, the attachment members are arranged along both sides of the end effector.

In at least one embodiment, the instrument further includes a driving mechanism configured to drive the fold over a side portion of the end effector.

In at least one embodiment, the driving mechanism is configured to drive tissue of the stomach into a conformation comprising the fold.

In at least one embodiment, the instrument further includes a pair of the driving mechanisms one on the first side and one on the second side, the mechanisms configured to drive a pair of folds over opposite side portions of the end effector.

In at least one embodiment, the instrument further includes receptacles configured to receive and attach to the attachment members after the attachment members are driven through the fold.

In at least one embodiment, the instrument further includes a conjunction member connected to the plurality of attachment members.

In at least one embodiment, the conjunction member is connected to the attachment members via sutures.

In at least one embodiment, the lengths of the sutures between the conjunction member and the attachments members are adjustable.

In at least one embodiment, the conjunction member is configured to encourage tissue ingrowth on a first surface and is configured to prevent tissue ingrowth on an opposite surface.

In at least one embodiment, the instrument is provided in combination with an implantable device releasably attached to the instrument.

In another aspect of the present invention, a system for use in modifying a patient's stomach by operating on the stomach extragastric ally to decrease the effective volume of the patient's stomach is provided including: an instrument including: an elongate end effector at a distal end portion of the instrument, the end effector having a distal end, a proximal end and first and second sides; an elongate shaft extending proximally from the proximal end of the end effector, the shaft having sufficient length so that a proximal end of the shaft extends out of the patient's body when the end effector is placed on the patient's stomach; a plurality of piercing members extending lengthwise along the end effector; and a plurality of attachment members extending lengthwise along the end effector, the attachment members configured and positioned to be driven through a fold in the stomach; and an expandable, implantable device releasably attached to the instrument.

In at least one embodiment, the system further includes a driving mechanism configured to drive a fold of the stomach tissue over the device and a side portion of the end effector.

In at least one embodiment, the system further includes a pair of the driving mechanisms configured to drive a pair of folds of the stomach tissue over the device and opposite side portions of the end effector.

In at least one embodiment, the system further includes a conjunction member connected to the plurality of attachment members.

In at least one embodiment, the conjunction member is configured to encourage tissue ingrowth on a first surface and is configured to prevent tissue ingrowth on an opposite surface.

In another aspect of the present invention, a kit for use in modifying a patient's stomach by operating on the stomach extragastrically to decrease the effective volume of the

patient's stomach is provided that includes: an implantable device comprising an elongate, tubular expandable member configured and dimensioned to be implanted between a fold created externally on the stomach and an external surface of the stomach; and a conjunction member having first and second opposite surfaces, the first surface being configured to contact the fold and encourage tissue ingrowth; the second surface being configured to prevent tissue ingrowth.

In at least one embodiment, the device is configured and dimensioned to be implanted between a pair of folds created externally on the stomach and an external surface of the stomach, and the conjunction member is configured to bridge and conjoin the two folds.

In at least one embodiment, the device further comprises a conduit in fluid communication with the expandable member, the conduit extending from an end of the expandable member.

In at least one embodiment, the kit further includes a bougie configured and dimensioned to be temporarily inserted in the stomach to function as a guide for placement of formation of the fold and placement of the device.

In at least one embodiment, an instrument for use in modifying a patient's stomach by operating on the stomach extragastrically to decrease the effective volume of the patient's stomach includes a first elongate end effector formed at a distal end portion of said instrument, said first elongate end effector having a first operational surface configured to contact an external surface of the patient's stomach and a first plurality of suction ports extending along a length of said first elongate end effector and configured to deliver suction to the external surface of the stomach to engage said first elongate end effector therewith, at least one suction port includes a means for providing a physical barrier to the escape of a portion of the stomach from the suction port.

In at least one embodiment, the instrument includes at least one suction hole configured to hold the stomach against an interior surface of a lip of the suction port. In at least one embodiment, the at least one suction hole is configured within a cavity of the suction port to create a concave curve in a portion of the stomach near the interior surface of a lip of the suction port. In at least one embodiment, the suction port includes at least one vacuum channel. In at least one embodiment, the suction port includes a tissue excluder configured to exclude the stomach from the at least one vacuum channel.

In at least one embodiment, the suction port includes a resilient member configured to deflect as suction is delivered to the external surface of the stomach. In at least one embodiment, the resilient member is configured to extend from the first operational surface toward the external surface of the stomach. In at least one embodiment, the resilient member includes at least one slot. In at least one embodiment, the resilient member is configured to extend parallel to an opening of the suction port. In at least one embodiment, the resilient member is configured to extend from an interior surface of the suction port.

In at least one embodiment, the instrument includes a second elongate end effector formed at a distal end portion of said instrument, said second elongate end effector having a second operational surface configured to contact an external surface of the patient's stomach, and a second plurality of suction ports extending along a length of said second elongate end effector and configured to deliver suction to the external surface of the stomach to engage said second elongate end effector therewith, at least one suction port includes a means for providing a physical bather to the escape of the stomach from the suction port.

In at least one embodiment, the instrument includes a connector in fluid communication with the first elongate end effector and the second elongate end effector. In at least one embodiment, the connector includes telescoping segments. In at least one embodiment, the connector is biased to hold the first elongate end effector and the second elongate end effector apart from each other. In at least one embodiment, the connector is biased to hold the first elongate end effector and the second elongate end effector together.

In at least one embodiment, an instrument for use in modifying a patient's stomach by operating on the stomach extragastrically to decrease the effective volume of the patient's stomach includes at least two elongate end effectors formed at a distal end portion of said instrument, a plurality of suction ports extending along a length of each elongate end effector, and a resilient and flexible member proximate at least one suction port wherein the member is configured to provide a physical barrier to the escape of a portion of the stomach from the suction port.

In at least one embodiment, at least a portion of the member is within the suction port. In at least one embodiment, the member is entirely within the suction port. In at least one embodiment, the member is outside the suction port.

In at least one embodiment, an instrument for use in modifying a patient's stomach by operating on the stomach extragastrically to decrease the effective volume of the patient's stomach includes at least two elongate end effectors formed at a distal end portion of said instrument and a plurality of suction ports extending along a length of each elongate end effector and configured to deliver suction to the external surface of the stomach to engage each end effector therewith, wherein at least one port includes an interior lip configured to maintain contact with the stomach when a portion of the stomach is within the suction port.

In at least one embodiment, the suction port includes channels. In at least one embodiment, the suction port includes a tissue excluder. In at least one embodiment, the suction port includes a suction hole proximate the interior lip.

These and other features of the invention will become apparent to those persons skilled in the art upon reading the details of the instruments, implants, systems and methods as more fully described below.

BRIEF DESCRIPTION OF THE DRAWINGS

FIG. **1**A illustrates basic anatomy of the human stomach.

FIG. **1**B is a partial, sectional illustration showing different layers of the stomach wall.

FIGS. **2**A-**2**K illustrate various events for the performance of a procedure for decreasing the effective volume of a patient's stomach that includes extragastric procedures on the stomach to create at least one plication, according to an embodiment of the present invention.

FIGS. **3**A-**3**H are various views and partial views of an instrument including end effectors for operating on a stomach extragastrically to decrease the effective volume of the stomach according to an embodiment of the present invention.

FIGS. **4**A-**4**D illustrate a stomach that has been reduced in effective volume by a procedure according to an embodiment of the present invention.

FIGS. **5**A-**5**L illustrate various events for the performance of a procedure for decreasing the effective volume of a patient's stomach that includes extragastric procedures on the stomach to create at least one plication, according to another embodiment of the present invention.

FIGS. **5**M-**5**R schematically illustrate an alternative embodiment to the instrumentation used in FIGS. **5**A-**5**L, according to an embodiment of the present invention.

FIG. **6** illustrates an instrument that can function as a bougie, according to an embodiment of the present invention.

FIGS. **7**A-**7**I illustrate various events for the performance of a procedure in which a device is implanted within plications formed at external locations of the stomach according to an embodiment of the present invention.

FIGS. **8**A-**8**S are various views and partial views of an attachment instrument according to an embodiment of the present invention, and of a method of performing a plication therewith according to an embodiment of the present invention.

FIG. **9** is a schematic illustration of an alternative mechanism for making a stitch (or simultaneous stitches) through tissue according to an embodiment of the present invention.

FIGS. **10**A-**10**J illustrate various events for the performance of a procedure in which a device is implanted within plications formed at external locations of the stomach according to an embodiment of the present invention.

FIGS. **11**A-**11**S illustrate various events for the performance of a procedure in which a device is implanted within plications formed at external locations of the stomach according to an embodiment of the present invention.

FIGS. **12**A and **12**G-**12**I are various views of an end effector according to an embodiment of the present invention.

FIGS. **12**B-**12**F illustrate a method of using the end effector of FIGS. **12**A and **12**G-**12**I according to an embodiment of the present invention.

FIGS. **13**A-**13**G show various views of an end effector according to another embodiment of the present invention and a method of using it according to another embodiment of the present invention.

FIGS. **14**A-**14**B are a top view and perspective view, respectively, of an end effector according to another embodiment of the present invention.

FIGS. **15**A-**15**E are various views showing an instrument that includes suction for holding stomach tissue in place during a plication procedure, and use thereof, according to an embodiment of the present invention.

FIGS. **16**A-**16**D illustrate use of vacuum to ascertain proper placement of plicated tissue according to embodiments of the present invention.

FIGS. **17**A-**17**E are various views of an attachment instrument and use thereof, according to another embodiment of the present invention.

FIGS. **18**A-**18**H are various views illustrating an instrument and use thereof to perform a plication according to embodiments of the present invention.

FIGS. **19**A-**19**B are views of an instrument and stomach illustrating use of the instrument to perform a plication according to another embodiment of the present invention.

FIGS. **20**A-**20**B illustrate use of an instrument to perform a plication according to another embodiment of the present invention.

FIGS. **21**A-**21**C illustrate a method of performing a plication according to another embodiment of the present invention.

FIGS. **22**A-**22**B illustrate a device and a method of performing a plication according to another embodiment of the present invention.

FIGS. **23**A-**23**E are various view of an instrument for performing plication according to another embodiment of the present invention.

FIGS. **24**A-**24**D are various views of another instrument for use in performing plication, according to an embodiment of the present invention.

FIGS. **25**A-**25**B are views of another instrument for use in performing plication, according to an embodiment of the present invention.

FIGS. **26**A-**26**D illustrate various events in performing a plication according to another embodiment of the present invention.

FIGS. **27**A-**27**B illustrate an instrument and performance of a plication according to another embodiment of the present invention.

FIGS. **28**A-**28**G illustrate an instrument and use thereof for forming a plication as well as functioning as a bougie according an embodiment of the present invention.

FIGS. **29**A-**29**D illustrate an instrument and use thereof for forming a plication as well as functioning as a bougie according an embodiment of the present invention.

FIGS. **30**A-**30**D illustrate an instrument for deforming tissues to be sutured and suturing the tissues, according to an embodiment of the present invention.

FIGS. **31**A-**31**B illustrate a plan view and a partial view, respectively, of a view of an instrument that can be used to manipulate stomach tissue in furtherance of a plication procedure according to an embodiment of the present invention.

FIGS. **32**A-**32**C illustrate an instrument for use in performing a plication according to another embodiment of the present invention.

FIG. **33** illustrates instruments for use in performing a plication according to another embodiment of the present invention.

FIG. **34** illustrates an implant according to an embodiment of the present invention.

FIGS. **35**A-**35**F are various views of an instrument for use in performing a plication according to another embodiment of the present invention.

FIGS. **36**A-**36**B are views of an instrument for use in performing a plication that is completed by manual suturing according to an embodiment of the present invention.

FIG. **36**C illustrates manual suturing of a plication line according to an embodiment of the present invention.

FIGS. **36**D-**36**E are perspective and cross-sectional illustrations, respectively, of a stomach having a plication with two suture lines installed according to an embodiment of the present invention.

FIGS. **36**F-**36**G are perspective and cross-sectional illustrations, respectively, of a stomach having a plication with one suture line installed according to an embodiment of the present invention.

FIGS. **37**A-**37**C are schematic views illustrating a mechanism for engaging stomach tissue according to an embodiment of the present invention.

FIGS. **38**A-**38**H provide various partial views of an instrument that employs suction as a primary clamping feature and a mechanical secondary clamping feature according to an embodiment of the present invention.

FIGS. **39**A-**39**K illustrate various events for the performance of a procedure for decreasing the effective volume of a patient's stomach that includes extragastric procedures on the stomach to create at least one plication, according to another embodiment of the present invention.

FIGS. **40**A-**40**F illustrate various attachment tabs or fins accordance to various embodiments of the present invention.

FIGS. **41**A-**41**E illustrate various schematic views and partial views of a driving mechanism according to an embodiment of the present invention.

FIGS. **42**A-**42**B illustrate partial schematic views of an end effector having a driving mechanism according to another embodiment of the present invention.

FIGS. **43**A-**43**C illustrate arrangements and methods for installing a running stitch using an attachment instrument according to various embodiments of the present invention.

FIGS. **44**A-**44**B illustrate views of an embodiment of a handle portion of an instrument capable of operating end effectors designed according to certain aspects of the present invention.

FIGS. **45**A-**45**C illustrate views of various clamping mechanisms for use with end effectors according to certain embodiments of the present invention.

FIGS. **46**A-**46**B illustrate views of an end effector assembly including telescoping connectors according to certain embodiments of the present invention.

FIGS. **46**C-**46**F illustrate views of various suction connectors for use with end effectors according to certain embodiments of the present invention.

FIGS. **47**A-**47**N illustrate views of various suction ports for use with end effectors according to certain embodiments of the present invention.

FIGS. **48**A-**48**B illustrate perspective views of a modular system of end effectors and suction ports according to certain embodiments of the present invention.

FIGS. **49**A-**49**B illustrate views of a mechanism for engaging stomach tissue according to an embodiment of the present invention.

DETAILED DESCRIPTION OF THE INVENTION

Before the present systems, devices and methods are described, it is to be understood that this invention is not limited to particular embodiments described, as such may, of course, vary. It is also to be understood that the terminology used herein is for the purpose of describing particular embodiments only, and is not intended to be limiting, since the scope of the present invention will be limited only by the appended claims.

Where a range of values is provided, it is understood that each intervening value, to the tenth of the unit of the lower limit unless the context clearly dictates otherwise, between the upper and lower limits of that range is also specifically disclosed. Each smaller range between any stated value or intervening value in a stated range and any other stated or intervening value in that stated range is encompassed within the invention. The upper and lower limits of these smaller ranges may independently be included or excluded in the range, and each range where either, neither or both limits are included in the smaller ranges is also encompassed within the invention, subject to any specifically excluded limit in the stated range. Where the stated range includes one or both of the limits, ranges excluding either or both of those included limits are also included in the invention.

Unless defined otherwise, all technical and scientific terms used herein have the same meaning as commonly understood by one of ordinary skill in the art to which this invention belongs. Although any methods and materials similar or equivalent to those described herein can be used in the practice or testing of the present invention, the preferred methods and materials are now described. All publications mentioned herein are incorporated herein by reference to disclose and describe the methods and/or materials in connection with which the publications are cited.

It must be noted that as used herein and in the appended claims, the singular forms "a", "an", and "the" include plural referents unless the context clearly dictates otherwise. Thus, for example, reference to "a suture" includes a plurality of such sutures and reference to "the anchor" includes reference to one or more anchors and equivalents thereof known to those skilled in the art, and so forth.

The publications discussed herein are provided solely for their disclosure prior to the filing date of the present application. Nothing herein is to be construed as an admission that the present invention is not entitled to antedate such publication by virtue of prior invention. Further, the dates of publication provided may be different from the actual publication dates which may need to be independently confirmed.

Stomach Anatomy

The stomach **3** is divided into four sections, as indicated by the dashed lines on FIG. **1**A. The cardia **3**C (see FIG. **1**A) is the section that receives the contents of the esophagus **4** to be delivered into the stomach **3**. The fundus **3**F is the section formed by the upper curvature of the stomach **3**. The body **3**B is the main, central region of the stomach, and the pylorus **3**P is the lower section of the stomach **3** that facilitates emptying of the contents of the stomach **3** into the small intestine/duodenum. The region between the body **3**B and pylorus **3**P is referred to as the pyloric antrum **3**PA. The greater curvature **3**G of the stomach is directed mainly forward and is typically about four or five times as long as the lesser curvature **3**L of the stomach, that is formed on the opposite side of the stomach **3** from the greater curvature **3**G.

The stomach wall is made up of layers of tissues. The serosa or serosal layer **3**S forms the outer layer of the stomach wall **3**W, see FIG. **1**B, and covers the muscularis layer **3**M. The mucosa or mucosal layer **3**MU forms the inner lining of the stomach, and the submucosal layer **3**SM interconnects the mucosa **3**MU with the muscularis **3**M.

Methods, Instruments, Devices and Systems

The present invention provides methods, instruments, devices and systems for reducing the effective volume of a stomach by performing one or more extragastric plications of the stomach. As noted, the plications are performed from outside of the stomach. In some, but not all embodiments, the plication results from attachment that does not penetrate through the entire wall of the stomach. Preferably, in performing plication, the one or more plications formed place stomach tissue in serosa to serosa contact, wherein the stomach is folded in on itself and connected in place. Procedures described are repeatable to reliably form a pathway through the stomach that is substantially tube-shaped and which has a diameter which is not too small anywhere along the length thereof to raise an unacceptable risk of obstruction, but which is not too large anywhere along the length thereof to render its weight loss results less effective than expected. In one category, typically, but not necessarily performed by a laparoscopic or percutaneous procedure, only connectors are left in place at the surgical site upon formation of one or more plications. In a second category, a device is inserted within one or more plications, between external wall surfaces of the stomach **3**, and is fixed in place there using connectors. Connectors are also used to maintain the plications in place. Preferably the size/volume of the device is adjustable, so that it can be adjusted, after implantation, to provide more or less reduction in the overall internal stomach space. It is noted that although certain embodiments are described with regard to practicing a procedure in the first category, and other specific embodiments are described in regard to practicing a procedure in the second category, the invention is not limited to these embodiments, and each embodiment of instrument/system described can be used to practice either category of procedure unless it would be physically impossible to do so. Also, it is noted that certain features of instruments are

described with regard to a particular embodiment, but these features may be interchangeable with other embodiments described herein.

In at least one embodiment, the omentum is dissected from the greater curvature of the stomach. The stomach is rolled up, starting from the greater curvature, toward the lesser curvature, and then the rolled up portion is stitched along at least the superior portion (upper one third of the stomach) to create a pouch and narrowing near the top of the stomach. Optionally an extragastric, expandable implant may be placed in contact with the rolled up portion to provide further assurance of prevention of unrolling and to provide further adjustability of the remaining pouch and sleeve formed by the rolling and stitching.

Referring now to FIGS. **2**A-**2**K, various events are illustrated for the performance of a procedure for decreasing the effective volume of a patient's stomach that includes extragastric procedures on the stomach to create at least one plication, typically a plication including at least a portion of the greater curve **3**G of the stomach **3**. Accordingly these procedures can be referred to as "greater curve plication" procedures. The procedure shown in FIGS. **2**A-**2**K is a laparoscopic procedure in which ports are installed in a patient for access to the abdominal cavity by not only the instrument shown, but also by other instruments typically used in laparoscopic surgery, such as graspers, endoscope, etc.

After establishing ports/pathway into the abdominal cavity from outside the patient, the omentum **5** and connective tissues are dissected at the greater curve **3**G of the stomach **3** to provide access thereto, see FIGS. **2**A-**2**B. A bougie **50** is inserted trans-esophageally and placed in the stomach **3** in a position such as shown in FIG. **2**C. Typically the bougie occupies a pathway extending naturally from the esophagus, through the stomach **3** and into the pylorus **3**P, so as to occupy a space similar to what is defined when a sleeve gastrectomy is performed. In one example, the bougie **50** was a size 32 French outside diameter, although this size may vary, up to and including 38 French and 40 French, for example. The bougie **50** acts as a guide so as to better standardize the size(s) and location(s) of plication(s) formed by the procedure as well as to prevent reducing the stomach too aggressively, so as to ensure no blockage locations are inadvertently formed.

An attachment instrument **100** is inserted into the abdominal cavity and a working end is positioned over a location on the stomach where a plication line is intended to be formed. The working end is the distal end portion of the instrument **100** and includes a first end effector **100**E**1** and a second end effector **100**E**2** extending alongside and opposing first end effector **100**E**1**. One of the end effectors **100**E**1**, **100**E**2** is placed on a posterior surface of the stomach and the other is placed on an anterior surface of the stomach along a line opposed to a line of the posterior surface that the first end effector contacts. In the embodiment shown in FIG. **2**D, end effector **100**E**1** is contacted to the anterior surface, and end effector **100**E**2** is contacted to the posterior surface. Alternatively, end effector **100**E**1** could be contacted to the posterior surface, and end effector **100**E**2** could be contacted to the anterior surface. The end effectors **100** are positioned close to the bougie **50** so that the diameter of the bougie defines the resulting lumen in the stomach after the plication has been sutured. Optionally, the end effectors may have features that can be adjusted by the surgeon. These features would extend the width of the end effector on the side that is closest to the bougie. This would enable the surgeon to adjust how close the suturing can be placed relative to the bougie. These adjustments could be made differently at the most distal end of the end effectors, compared to the most proximal ends of the end effectors. In this manner, the surgeon could make adjustments to cause the ultimate size of the stomach's lumen to be tighter at the antrum end of the stomach, and looser at the fundus of the stomach, or vice versa. Another option is that the diameter of the bougie can be changed. With the bougie used as a guide for the initial positioning of the end effectors on the stomach's surface such that the end effectors are placed immediately adjacent to the bougie prior to gripping the stomach, the diameter or width of the bougie after gripping but prior to imbricating the stomach can be reduced to allow space between the bougie and the end effectors for the imbricated stomach tissue. This could be accomplished with a two-part bougie, one part of which is removed prior to imbrication, or with an inflatable bougie that allows its diameter to be adjusted while in place.

The end effectors **100**E**1**, **100**E**2** engage the surfaces of the stomach that they are contacted to by application of negative pressure through suction ports defined in the contact surfaces of the end effectors, which are described in further detail below. The engagement forces are sufficiently strong so that when the end effectors **100**E**1**, **100**E**2** are separated (moved away from one another) as illustrated in FIG. **2**E, the portions of the stomach wall engaged by the end effectors are also drawn apart, thereby expanding the interior volume within the stomach. Alternative to moving both end effectors **100**E**1**, **100**E**2** apart from each other, end effector **100**E**2** can be maintained stationary while end effector **100**E**1** is move away from it or end effector **100**E**1** can be maintained stationary while end effector **100**E**2** is moved away from it.

Next, a portion of the stomach forming at least a portion of the greater curvature **3**G is plicated, i.e., tucked, into the gap **100**G formed by separating the end effectors **100**E**1**, **100**E**2** as illustrated in FIG. **2**F. The plicated portion of the stomach is folded to an extent that it is located on the opposite side of the intended plication line, relative to its pre-plicated location, as can be observed by comparing FIG. **2**E with FIG. **2**F. Optionally, but preferably, prior to plicating the portion of the stomach, the operator of the instrument **100** may rotate the instrument by about ninety degrees (counterclockwise in the embodiment shown in optional step of FIG. **2**F') about its longitudinal axis. This option positions the stomach to allow gravity to assist in plicating the portion **3**G through the gap **100**G, making the plicating much easier as the portion **3**G "falls" in through gap **100**G.

Once the portion **3**G has been plicated appropriately according to either optional technique described above, the instrument **100** is then operated to move the end effectors **100**E**1**, **100**E**2** together again thereby closing the plication as illustrated in FIG. **2**G. During this step, and throughout the following steps, the instrument can be maintained in the rotated orientation (as shown in FIG. **2**F') or it can be rotated back to the original orientation shown in FIG. **2**G. Next instrument **100** is operated to attach the folded tissue surfaces of the stomach together in serosa-to-serosa contact to hold the plication. At FIG. **2**H piercing members/suture drivers **102** (preferably needles, but could alternately be screw drives or other elongated members configured to temporarily attach attachment members/sutures to and to drive through the stomach tissues) are deployed from end effector **100**E**1** to drive attachment members/sutures **104** through the stomach tissues as shown. It should be noted that while FIG. **2**H shows the needles penetrating the stomach tissue in a manner where they penetrate through four walls of tissue, the device can alternatively be configured to control the stomach tissue into a position with the location of the suction features such that the needles pierce closer to the edges of the folds. This would enable the needles and suture to transect the wall thickness of

the stomach, but not breach the inner surface of the stomach. This alternative approach can be taken for all of the various embodiments described herein. Suture anchors **106** are removably held in end effector **100**E**2** and are aligned with the piercing member/suture drivers **102**. Attachment members/sutures **104** are releasably engaged with piercing members/suture drivers **102**. In the embodiment shown in FIG. **2**H, attachment members/sutures **104** are each provided with an anchor mate **108** on a distal end portion thereof, preferably at the distal end thereof. Anchor mate **108** is configured to slide over the tapered distal end portion of the suture driver **102**, but is prevented from sliding further proximally by the increasing diameter of the taper of the driver **102** distal end portion. The exterior of the anchor mate **108** is also tapered, so that the distal end **108**D thereof is of a smaller cross-sectional dimension than the proximal end **108**P thereof. This facilitates the driving of the anchor mate **108** into the anchor **106** as shown in FIG. **2**H. However, upon withdrawal of the suture driver, the proximal end of the anchor mate **108**P is retained by the anchor **106** and the anchor mate **108** slides off the suture driver **102**, thereby leaving the anchor mate **108** and suture **104** installed through the tissues as illustrated in FIG. **2**I. The end effectors **100**E**1**, **100**E**2** are designed so that the suture connection elements **102**, **104**, **106**, **108** are repeated along the length of the end effectors, spaced approximately 0.75" from center to center. These repeated elements therefore deploy the suture connection along the length of the desired plication line. It is noted here that if the optional rotation is performed in FIG. **2**F', then the instrument is counter-rotated by the amount about the longitudinal axis thereof, to return the stomach to the orientation shown in FIG. **2**G or FIG. **2**H, either after performing the procedures described above with regard to FIG. **2**G or after performing the procedures described above with regard to FIG. **2**H.

Attachment members/sutures **104** are also pre-installed through suture locks **110** that are removably mounted on end effector **100**E**1** and are mounted on attachment members/sutures **104** proximal to the piercing members/suture drivers **102**. Once the attachment members/sutures have been driven and anchored as illustrated in FIG. **2**H and the stomach has been rotated back to its original orientation, if applicable, instrument **100** is removed from the patient, leaving the attachment members/sutures **104**, suture locks **110**, suture anchors **106** and suture anchor mates **108** in place as illustrated in FIG. **2**I. Suture locks **110** have a one-way locking mechanism, such as a ratcheting type mechanism or other arrangement such as directionally oriented teeth that allow suture **104** to be pulled proximally therethrough, but which prevent attachment members/sutures **104** from backsliding distally therethrough. At FIG. **2**J, the attachment members/sutures **104** are cinched by pulling them proximally relative to the suture locks **110** until a desired amount of tension is developed in the attachment members/sutures **104**. The attachment members/sutures are cinched tight enough to bring the tissue surfaces into firm contact without creating tissue necrosis or overtightening. Cinching can be performed by the use of laparoscopic graspers (not shown), for example. The bougie **50** can then be removed from the patient and the patient can be closed, according to known techniques, to complete the procedure. Alternatively, the suture locks **110** can be located in end effector **100**E**1**, but on the posterior side in contact with the stomach tissue. Alternatively, the instrument **100** can be left in place until after the sutures **104** are cinched tight and trimmed by the instrument **100**, and afterwards the instrument **100** can be removed, leaving the result shown in FIG. **2**J. Alternatively, staples or other fasteners could be used in place of the sutures, suture locks, suture anchors and mating anchors.

As a further option, an expandable implant **10** may be implanted to fill the inside of the plication **3**PL as illustrated in FIG. **2**K. The implant may be a silicone bladder, for example, capable of being inflated by biocompatible fluid such as liquid, gas, or a combination of fluids (gases, liquids, or liquids and gases). Implant **10** is connected in fluid communication to a subcutaneous fill port **80** via fill tube **12** (such as illustrated in FIG. **7**H, for example, and described in detail in our previous applications which have been incorporated herein, in their entireties, by reference thereto). Subcutaneous fill port **80** can be accessed after completion of the procedure to adjust the fill volume (either increase or decrease) of implant **10**. Other implants **10** may be substituted, but need to be expandable and are preferably controllable as to amount of expansion. A tab or wing **11**, **11'**, **11"**, **11'"** may be provided to extend from the expandable body of the implant **10** and can be inserted between the tissue folds at the plication suture line so that the attachment members/sutures **104** are also installed through the tab or wing **11**, **11'**, **11"**, **11'"** to thereby securely hold the implant in place, as illustrated in FIG. **2**K. The tab or wing **11**, **11'**, **11"**, **11'"** may be made of a mesh-reinforced silicone, for example. Alternatively, all or a portion of tab or wing **11**, **11'**, **11"**, **11'"** may be made of a tissue ingrowth encouraging material such as DACRON or the like. Alternatively, the implant may be fixed in place by connecting only to the superior and inferior ends of the plication suture line, or by connecting to one or more of the suture locks **110** and/or suture anchors **106**. By making the exteriors of the tab or wing **11**, **11'**, **11"**, **11'"** of silicone, this will prevent tissue ingrowth, rendering the sutured plication procedure reversible. Alternatively, by providing the mesh layers on the surface(s) of the tab or wing **11**, this will encourage tissue ingrowth, thereby reinforcing the joinder of the serosa-to-serosa plication line. Alternatively, the wing **11**, **11'**, **11"**, **11'"** can have a shape along its length that is castellated with extensions and indentations, where the extended sections along the length engage with the sutures **104**, and where the indentations between the extensions allow the serosa to serosa contact between the stomach tissues to remain and allow for adhesion and tissue ingrowth. The tab or wing **11**,**11'**,**11"**,**11'"** may be a fin, which may be longitudinally extending such that it has a length greater than width such as illustrated in FIGS. **40**A-**4**F, such that it extends along the implant **10** by a greater distance than the distance that it extends from the implant **10**. Alternatively, the tab **11**,**11'**,**11"**,**11'"** could extend from the implant **10** by a distance greater than a distance that it extends along the implant **10**. The fin may be continuous, porous, or may consist of a series of fingers. The embodiments are shown as linear embodiments, but it is within the scope of the present invention that the implant and tab, wing or fin be curved or that the tab, wing or fin be curved, or that the tab, wing or fin may be discontinuous in the length direction. FIGS. **40**A-**40**B illustrate an embodiment in which fin **11'** includes a plurality of fingers **11**F with gaps **11**G therebetween. FIGS. **40**C-**40**F show embodiments of fins **11"** and **11'"**, respectively, each having pores **11**P therethrough. Pores **11**P may be dimensioned to allow tissue to grow between and across on either side of the fin **11"**, **11'** (and through pores **11**P). The plication attachment devices described herein may be designed to attach within/through the pores **11**P/gaps **11**G or through the solid regions **11**S between the pores **11**P/gaps **11**G. The fingers **11**F may be spaced so that they traverse the space between the plication attachment locations or they may be captured in part or in full under the locations/attachment

points on the instrument. The material of the fin **11**, **11'**, **11"**, **11"'** may be of a tissue ingrowth preventing material such as silicone or the like, or may be made partly or entirely of a mesh-like or tissue ingrowth promoting material such as DACRON or the like. The fin **11**, **11'**, **11"**, **11"'** should have enough flexibility to be adhered within the plication yet minimize the force imparted by the device on the attachment points. The fin **11**, **11'**, **11"**, **11"'** may have a coupling region that temporarily aligns it with the plication attachment instrument so that it is properly located while the plication attachments are being formed.

FIG. **3**A is a perspective view of instrument **100** including end effectors **100**E**1** and **100**E**2** for operating on the stomach extragastrically to decrease the effective volume of the patient's stomach according to an embodiment of the present invention. First and second elongate end effectors **100**E**1**, **100**E**2** are formed at a distal end portion of instrument **100**. End effector **100**E**1** has an operational surface **100**ES**1** configured to contact an external surface of the patient's stomach **3** and end effector **100**E**2** has an operational surface **100**ES**2** configured to contact an external surface of the patient's stomach on a location opposite of where the first elongate end effector **100**E**1** is configured to contact the external surface of the stomach, and operational surface **100**ES**2** opposes operational surface **100**ES**1** as shown best in FIG. **3**B.

A plurality of suction ports **112** are formed in both end effectors **100**E**1**, **100**E**2**. Suction ports **112** are oriented to extend along a length of each end effector, and are in fluid communication with a source of negative pressure (not shown) provided outside of the patient, proximal of the handle **114** on the proximal end portion of instrument **100** (see FIG. **1**). For example, a suction line **116** that is in fluid communication with ports **112** may extend proximally from handle **114** and be configured for connection to a source of negative pressure, such as the suction system of an operating room or other source of negative pressure. Thus the end effectors **100**E**1**, **100**E**2** are configured to deliver suction to the external surfaces of the stomach **3** to engage the surfaces.

The end effectors **100**E**1**, **100**E**2** are substantially equal in length and have a length at least greater than half the length of the stomach, more preferably a length nearly as long as or even longer than the length of the stomach. The length is typically a length selected from a range of lengths of instruments. The instrument **100** may be manufactured as a plurality of models having end effectors with different lengths so as to accommodate various lengths of patient's stomachs.

As noted above and illustrated with regard to FIGS. **2**D-**2**E, suction ports **112** are configured to apply suction in an amount sufficient to pull opposite walls of the stomach apart when the end effectors **100**E**1**, **100**E**2** are engaged therewith and are moved apart from one another. This pulls the opposite walls apart without losing engagement of the end effectors with the walls.

The end effectors **100**E**1** and **100**E**2** are pivotally connected at proximal end portions thereof as shown in FIGS. **3**A, **3**E, **3**G and **3**H by joint mechanism **118**. Joint mechanism **118** is a complex joint mechanism that facilitates not only pivoting of the end effectors relative to one another as illustrated in FIGS. **3**A and **3**E, but also allows the end effectors to be moved non-rotationally, such that they remain parallel to one another over a range of motion from a closed configuration (see FIG. **3**G) to and open configuration (see FIG. **3**H). Accordingly, instrument **100** can be operated to place the end effectors **100**E**1**, **100**E**2** into the open configuration of FIG. **3**H in which the end effectors are spaced apart but parallel to one another. End effectors **100**E**1**, **100**E**2** can further be pivoted relative to one another to further separate the free distal ends thereof by a separation distance greater than the distance between the proximal ends thereof, as shown in FIG. **3**A. This facilitates the positioning of the end effectors over the external posterior and anterior surfaces of the stomach. Once the end effectors **100**E**1**, **100**E**2** have been positioned over the intended location of the plication suture line, instrument **100** can be operated to pivot/rotate the end effectors **100**E**1**, **100**E**2** in the opposite direction to return them to the open position shown in FIG. **3**H so that the end effectors are once again parallel to one another. Then the end effectors **100**E**1**, **100**E**2** are moved toward the closed position, but only by an amount sufficient to close the folded stomach tissues therebetween, but not so much as to risk causing necrosis or other unnecessary tissue damage. The movements of the end effectors are such that they remain parallel to one another over the entire course of this clamping action. Alternatively, the linkage can allow the end effectors **100**E**1**, **100**E**2** to close so that the proximal end is slightly further apart than the distal end in order to compensate for the typically thicker stomach tissue near the antrum as compared to the thinner tissue near the fundus. The desired amount of clamping may be determined visually by the surgeon and/or feedback from one or more sensors such as a strain gauge or the like that may be provided in one or both of the end effectors (not shown). Alternatively, a linkage may be present at both the proximal end (as shown) and also at the distal end of the end effectors. If a linkage is present at both ends, it can provide improved alignment between the end effectors **100**E**1**, **100**E**2**, and also provide a stronger clamping force which can be advantageous when the suture connections are being deployed. Alternatively, the linkages at both ends can be replaced by a telescoping connection such as a pin that extends from a tubular hole as the end effectors **100**E**1**, **100**E**2** separate. In such a configuration, the clamping together of the end effectors could be accomplished by the device pulling on cables that are connected to the pin at each end, thereby drawing the pins back into their mating tubular holes and thereby drawing the end effectors back together. This configuration can advantageously draw the ends of the end effectors to varying degrees of closeness that are adjustable to accommodate varying thicknesses of stomach **3** tissue. For example, the distal end of the end effectors could be drawn together closer to clamp around the thinner tissue in the fundus area, compared to the thicker antrum area, where the end effectors could be drawn together less.

Handle **114** is mounted on a proximal end portion of an elongated shaft **120** that connects the end effectors **100**E**1**, **100**E**2** and connection mechanism **118** therewith, see FIG. **3**A. Shaft **120** houses suction line **116** as well as control cables connecting actuator **122** with a mechanism for driving piercing members/suture drivers **102**. Shaft **120** has a length sufficient to position handle **114** outside of the body of the patient when end effectors **100**E**1**, **100**E**2** are contacted to and engaged with stomach tissue in a manner as described above. Once the end effectors **100**E**1**, **100**E**2** have been clamped to close the plication by a sufficient force as described above and illustrated in FIG. **2**G, actuator **122** is squeezed to actuate the driving of the piercing members/suture drivers **102** as illustrated in FIG. **2**H.

As shown in FIG. **3**C, the suture locks **110** are removably mounted to the operational surface **100**ES**1** of end effector **100**E**1**. As shown in FIG. **3**D, the suture anchors **106** are removably mounted to the operational surface **100**ES**2** of end effector **100**E**2**. FIG. **3**E is a partial view of the instrument **100** (distal end portion view) showing the piercing members/suture drivers partially retracted after firing. FIG. **3**F is an enlarged detail view of the distal end of the end effector

100E1 of FIG. 3F that shows the suture driver 102, suture 104, suture lock 110 and anchor mate 108. As also shown in FIG. 3C-3D, suction ports are preferably shaped as elongated slots that are elongated in the direction of the longitudinal axes of the end effectors. FIG. 3G shows the end effectors 100E1, 100E2 in a clamped configuration. FIG. 3H shows the end effectors 100E1, 100E2 in an unclamped configuration in which they are spaced apart to provide a gap therebetween. It is noted that the joint/linkage 118 is configured to move the end effectors such that they remain substantially parallel to one another when moving between the clamped and unclamped configurations, but that it is also configured to pivot the end effectors relative to one another, as illustrated in FIGS. 3A and 3E.

FIGS. 4A-4D are photos of a stomach 3 after performing the procedure described above with regard to FIGS. 2A-2E, 2F' and 2G-2J. With this procedure, there are no anchors or attachment mechanisms left in the stomach. As such the stomach does not have any objects or items in it that it would otherwise try to digest or expel. In FIG. 4A, the stomach 3 has been rotated 90 degrees about is longitudinal axis so to show the posterior side of the stomach 3, showing the mating anchors 108 mated with the suture anchors 106 along the posterior side of the plication line 3PL. In FIG. 4B, the stomach 3 has been counter-rotated by 90 degrees from that in FIG. 4A to show the anterior side of the stomach 3. The suture locks 10 can be seen extending along the plication line 3PL and sutures 104 have been cinched but not yet trimmed. FIG. 4C is an anterior view of the stomach, like FIG. 4B, but wherein the bougie 50 has been removed from the stomach 3 by pulling it out of the esophagus 6 and the sutures 104 have been trimmed off adjacent the suture locks. FIG. 4D is a posterior view of the stomach 3, like FIG. 4A, but where the bougie 50 has been removed from the stomach.

FIGS. 5A-5L illustrate various events for the performance of a procedure alternative to the embodiments described above with regard to FIGS. 2A-2K, for decreasing the effective volume of a patient's stomach that includes extragastric procedures on the stomach to create at least one plication, typically a plication including at least a portion of the greater curve 3G of the stomach 3. Accordingly these procedures can be referred to as "greater curve plication" procedures. The procedures shown are laparoscopic procedures in which ports are installed in a patient for access to the abdominal cavity by not only the instruments shown, but also by other instruments typically used in laparoscopic surgery, such as graspers, endoscope, etc.

After establishing ports/pathway into the abdominal cavity from outside the patient, the omentum 5 and connective tissues are dissected at the greater curve 3G of the stomach 3 to provide access thereto, see FIGS. 5A-5B. A bougie 50 is inserted trans-esophageally and placed in the stomach 3 in a position such as shown in FIG. 5C. Typically the bougie 50 occupies a pathway extending naturally from the esophagus, through the stomach 3 and into the pylorus 3P, so as to occupy a space similar to what is defined when a sleeve gastrectomy is performed. The bougie 50 acts as a guide so as to better standardize the size(s) and location(s) of plication(s) formed by the procedure as well as to prevent reducing the stomach too aggressively, so as to ensure no blockage locations are inadvertently formed.

In the embodiments of FIGS. 5D-5L the functions of instrument 100 are divided among two instruments 200 and 250. Engagement instrument 200 is configured like instrument 100, but without the piercing members/suture drivers 102, attachment members/sutures 104, anchors 106, anchor mates 108, suture locks 110 or any of the actuation mechanisms for driving and attaching attachment members/sutures. However, suction ports 112 are provided in both end effectors in the same manner and connection/joint mechanism 118 is provided and functions in the same manner. Also included are shaft 120, handle 114 and suction line 116. Stitching instrument 250 is configured like instrument 100 with the piercing members/suture drivers 102, attachment members/sutures 104, anchors 106, anchor mates 108, suture locks 110 and actuation mechanisms therefore, but without suctions ports 112 (although, optionally, suction ports may be included in the end effectors of instrument 250) or connection/joint mechanism. Also included are shaft 120, handle 114 and, optionally, suction line 116.

Engagement instrument 200 is inserted into the abdominal cavity and a working end thereof is positioned over a location on the stomach 3 where a plication line 3PL is intended to be formed. The working end is the distal end portion of the instrument 200 and includes a first end effector 200E1 and a second end effector 200E2 extending alongside and opposing first end effector 200E1. One of the end effectors 200E1, 200E2 is placed on a posterior surface of the stomach 3 and the other is placed on an anterior surface of the stomach 3 along a line opposed to a line of the posterior surface that the first end effector contacts. In the embodiment shown in FIG. 5D, end effector 200E1 is contacted to the anterior surface, and end effector 200E2 is contacted to the posterior surface. Alternatively, end effector 200E1 could be contacted to the posterior surface, and end effector 200E2 could be contacted to the anterior surface.

The end effectors 200E1, 200E2 engage the surfaces of the stomach 3 that they are contacted to by application of negative pressure through suction ports defined in the contact surfaces of the end effectors, which are described above in further detail. The engagement forces are sufficiently strong so that when the end effectors 200E1, 200E2 are separated (moved away from one another) as illustrated in FIG. 5E, the portions of the stomach wall engaged by the end effectors are also drawn apart, thereby expanding the interior volume within the stomach 3.

Next, a portion of the stomach forming at least a portion of the greater curvature 3G is plicated (i.e., tucked) into the gap 200G formed by separating the end effectors 200E1, 200E2 as illustrated in FIG. 5F. The plicated portion of the stomach 3 is folded to an extent that it is located on the opposite side of the intended plication line, relative to its pre-plicated location, as can be observed by comparing FIG. 5E with FIG. 5F. Optionally, but preferably, prior to plicating the portion of the stomach 3, the operator of the instrument 200 may rotate the instrument 200 by about ninety degrees (counterclockwise in the embodiment shown in optional step of FIG. 5F'). about its longitudinal axis. This option positions the stomach 3 to allow gravity to assist in plicating the portion 3G through the gap 200G, making the plicating much easier as the portion 3G "falls" in through gap 200G.

Once the portion 3G has been folded appropriately according to either optional technique described above, the instrument 200 is then operated to move the end effectors 200E1, 200E2 together again thereby closing the plication as illustrated in FIG. 5G. Next the surgeon can use a standard laparoscopic needle driver and needle with suture attached thereto, to suture the plication manually. Alternatively, instrument 250 is mounted over the folded tissue layers of the plication so that third end effector 250E1 and fourth end effector 250E2 contact the tissues on opposite sides thereof as shown in FIG. 5H. Instrument 250 fits in gaps in the instrument 200 between suction ports 112. Additionally, a layer of material is mounted in instrument 250 which wraps around

from the operation surface of end effector **250**E**1** to the operational surface of end effector **250**E**2** (see FIG. **5**G) and overlies the locations of the operational surfaces where the piercing members/suture drivers are driven out from, as well as the locations where the suture anchors are removably mounted. After mounting as described, instrument **250** is operated to attach the folded tissue surfaces of the stomach together in serosa-to-serosa contact to hold the plication. At the same time the layer of material **230** is attached to the plication. Material **230** forms a barrier layer that spans the suture line to prevent herniation of the plicated stomach in between the attachment members/sutures, thereby greatly reducing the risk of ischemia. The barrier material may be a sheet or strip of silicone, with or without mesh reinforcement, for example. Whether or not reinforced, the exterior of the strip is silicone, to prevent tissue ingrowth. By preventing tissue ingrowth, this will facilitate reversal of the procedure/plication as the silicone strip will be easily removable. At FIG. **5**H piercing members/suture drivers **102** (preferably needles, but could alternately be screw drives or other elongated members configured to temporarily attach attachment members/sutures to and to drive through the stomach tissues) are deployed from end effector **250**E**1** to drive attachment members/sutures **104** through the material **230** and stomach tissues as shown in FIG. **5**I. Suture anchors **106** are removably held in end effector **250**E**2** and are aligned with the piercing members/suture drivers **102**. Attachment members/sutures **104** are releasably engaged with piercing members/suture drivers **102**. Upon withdrawal of the piercing members/suture drivers, the proximal ends of the suture mates **108**P are retained by the anchors **106** and the suture mates **108** slide off the piercing members/suture drivers **102**, thereby leaving the suture mates **108** and attachment members/sutures **104** installed through the tissues and material **230** as illustrated in FIG. **5**J. It is noted here that if the optional rotation is performed in FIG. **5**F', then the instrument is counter-rotated by the amount about the longitudinal axis thereof, to return the stomach **3** to the orientation shown in FIG. **5**G, FIG. **5**H, FIG. **5**I or FIG. **5**J, after performing the procedures described above with regard to FIG. **5**G or after performing the procedures described above with regard to FIG. **5**H, or after performing the procedures described above with regard to FIG. **5**I, or after performing the procedures described above with regard to FIG. **5**J.

Attachment members/sutures **104** are also pre-installed through suture locks **110** that are removably mounted on end effector **250**E**1** and are mounted on attachment members/sutures **104** proximal to the piercing members/suture drivers **102**. Once the attachment members/sutures have been driven and anchored as illustrated in FIG. **5**I and the stomach **3** has been rotated back to its original orientation, if applicable, instruments **250** and **200** are removed from the patient, leaving the attachment members/sutures **104**, suture locks **110**, material **230**, suture anchors **106** and suture anchor mates **108** in place as illustrated in FIG. **5**J. Suture locks **110** have a one-way locking mechanism, such as a ratcheting type mechanism or other arrangement such as directionally oriented teeth that allow suture **104** to be pulled proximally therethrough, but which prevent attachment members/sutures **104** from backsliding distally therethrough. At FIG. **5**K, the attachment members/sutures **104** are cinched by pulling them proximally relative to the suture locks **110** until a desired amount of tension is developed in the attachment members/sutures **104**, as described previously. Cinching can be performed by the use of laparoscopic graspers (not shown), for example. The bougie **50** can then be removed from the patient and the patient can be closed, according to known techniques, to complete the procedure.

As a further option, an expandable implant **10** may be implanted to fill the inside of the plication **3**PL as illustrated in FIG. **5**L. The implant **10** may be a silicone bladder, for example, capable of being inflated by biocompatible fluid such as liquid, gas, or a combination of fluids (gases, liquids, or liquids and gases). Implant **10** is connected via fill tubing **12** in fluid communication with a subcutaneous fill port **80**, so that the fill volume of implant **10** can be adjusted after implanting it as described from a location outside of the abdominal cavity (e.g., by an operator accessing the subcutaneous fill port **80** with a needle alone or a needle attached to a pressurized source of fluid). Other implants **10** may be substituted, but need to be expandable and are preferably controllable as to amount of expansion. A tab or wing **11**, **11'**, **11"**, **11'"** may be provided to extend from the expandable body of the implant **10** and can be inserted between the tissue folds at the plication suture line so that the attachment members/sutures **104** are also installed through the tab or wing **11**, **11'**, **11"**, **11'"** to thereby securely hold the implant in place, as illustrated in FIG. **5**L. The tab or wing **11**, **11'**, **11"**, **11'"** may be made of a mesh-reinforced silicone, for example. Alternatively, the implant **10** may be fixed in place by connecting only to the superior and inferior ends of the plication suture line, or by connecting to one or more of the suture locks **110** and/or suture anchors **106**.

FIGS. **5**M-**5**R schematically illustrate an alternative embodiment to the instrumentation used in FIGS. **5**A-**5**L, according to another embodiment of the present invention. In this embodiment, like the embodiment of FIGS. **5**A-**5**L, the procedures shown are laparoscopic procedures in which ports are installed in a patient for access to the abdominal cavity by not only the instruments shown, but also by other instruments typically used in laparoscopic surgery, such as graspers, endoscope, etc. After establishing ports/pathway into the abdominal cavity from outside the patient, the omentum **5** and connective tissues are dissected at the greater curve **3**G of the stomach **3** to provide access thereto, the same as in FIGS. **5**A-**5**B. A bougie **50** is inserted trans-esophageally and placed in the stomach **3** in a position such as shown in FIG. **5**C. Typically the bougie **50** occupies a pathway extending naturally from the esophagus, through the stomach **3** and into the pylorus **3**P, so as to occupy a space similar to what is defined when a sleeve gastrectomy is performed. The bougie **50** acts as a guide so as to better standardize the size(s) and location(s) of plication(s) formed by the procedure as well as to prevent reducing the stomach too aggressively, so as to ensure no blockage locations are inadvertently formed.

In the embodiment of FIGS. **5**M-**5**R, engagement instrument **200'** (which, like engagement instrument **200** may optionally include secondary, mechanical clamping capability as discussed in more detail below) is configured like instrument **200**, except the cross-sectional geometry of end effector **200**E' is more compact than end effector **200**E (when end effectors **200**E**1** and **200**E**2** are closed together), circular as shown, but could be oval, elliptical or other more compact cross-sectional geometry than that of instrument **200**, as can be observed by comparing FIG. **5**M with FIG. **5**D. This more compact cross-sectional configuration is designed to permit the end effector **200**E' to be inserted through a relatively smaller diameter port, such as a relatively smaller laparoscopic port. In one embodiment, the cross-sectional configuration of end effector **200**E' is configured to enable the end effector **200**E' to be passed through a laparoscopic port having a 15 mm inside diameter. The present invention is not limited to this dimension, as it is only an example, and larger or smaller end effectors **200**E' may be provided.

Like instrument **200**, instrument **200'** does not include piercing members/suture drivers **102**, attachment members/sutures **104**, anchors **106**, anchor mates **108**, suture locks **110** or any the actuation mechanisms for driving and attaching attachment members/sutures. However, suction ports **112** are provided in both end effectors **200**E**1'**, **200**E**2'** and may be in the same manner as in **200** and connection/joint mechanism **118** may be provided to function in the same manner. Also included are shaft **120** (not shown), handle **114** (not shown) and suction line **116** (not shown) all of which may be the same is in instrument **200**.

Stitching instrument **250'** is configured like instrument **250** except the cross-sectional geometry of the end effector **250**E' is more compact than that of end effector **250**E, circular as shown, but with a cutout region designed to be placed over the end effectors **200**E**1'**, **200**E**2'** as described below, but could be oval, elliptical or other more compact cross-sectional geometry while still retaining the cutout region **252**, as can be observed by comparing FIG. **5**O with FIG. **5**G. This more compact cross-sectional configuration is designed to permit the end effector **250**E' to be inserted through a relatively smaller diameter trocar cannula, such as a laparoscopic trocar cannula. In one embodiment, the cross-sectional configuration of end effector **250**E' is configured to enable the end effector **250**E' to be passed through a laparoscopic trocar cannula having a 15 mm inside diameter. The present invention is not limited to this dimension, as it is only an example, and larger or smaller end effectors **250**E' may be provided.

Engagement instrument **200'** is inserted into the abdominal cavity and a working end thereof is positioned over a location on the stomach **3** where a plication line **3**PL is intended to be formed, like in FIG. **5**D. The working end is the distal end portion of the instrument **200'** and includes a first end effector **200**E**1'** and a second end effector **200**E**2'** extending alongside and opposing first end effector **200**E**1'**, e.g., see FIG. **5**N. One of the end effectors **200**E**1**, **200**E**2** is placed on a posterior surface of the stomach **3** and the other is placed on an anterior surface of the stomach **3** along a line opposed to a line of the posterior surface that the first end effector contacts. As with instrument **200**, end effector **200**E**1** can be contacted to the anterior surface of the stomach **3**, and end effector **200**E**2'** can be contacted to the posterior surface. Alternatively, end effector **200**E**1'** could be contacted to the posterior surface, and end effector **200**E**2'** could be contacted to the anterior surface.

The end effectors **200**E**1'**, **200**E**2'** engage the surfaces of the stomach **3** that they are contacted to by application of negative pressure through suction ports defined in the contact surfaces of the end effectors, in the same manner as in instrument **200**. The engagement forces are sufficiently strong so that when the end effectors **200**E**1'**, **200**E**2'** are separated (moved away from one another, similar to what is shown in FIG. **5**E), the portions of the stomach wall engaged by the end effectors are also drawn apart, thereby expanding the interior volume within the stomach **3**. As already noted, instrument **200'**, like instrument **200** may optionally include secondary mechanical clamping of the stomach tissue **3** to reinforce the strength of engagement of the end effectors with the stomach tissues, further ensuring that the tissues do not prematurely separate from the end effectors.

Next, a portion of the stomach forming at least a portion of the greater curvature **3**G is plicated (i.e., tucked) into the gap **200**G formed by separating the end effectors **200**E**1'**, **200**E**2'**, like what is shown in FIG. **5**F. The plicated portion of the stomach **3** is folded to an extent that it is located on the opposite side of the intended plication line, relative to its pre-plicated location, as can be observed by comparing FIG. **5**E with FIG. **5**F. Optionally, but preferably, prior to plicating the portion of the stomach **3**, the operator of the instrument **200'** may rotate the instrument **200'** by about ninety degrees (counterclockwise, like the embodiment shown in the optional step of FIG. **5**F') about its longitudinal axis. This option positions the stomach **3** to allow gravity to assist in plicating the portion **3**G through the gap **200**G, making the plicating much easier as the portion **3**G "falls" in through gap **200**G.

Once the portion **3**G has been folded appropriately according to either optional technique described above, the instrument **200'** is then operated to move the end effectors **200**E**1'**, **200**E**2'** together again thereby closing the plication **3**PL as schematically illustrated in FIGS. **5**M-**5**N (distal end view and perspective view, respectively). Optionally the surgeon can use a standard laparoscopic needle driver and needle with suture attached thereto, to suture the plication manually by performing a line of interrupted sutures through slots **200**S. Alternatively, instrument **250'** is mounted over the folded tissue layers of the plication and instrument **200'** as illustrated in FIGS. **5**O-**5**P (distal end view and perspective view, respectively) so that third end effector **250**E**1'** and fourth end effector **250**E**2'** contact and overlie the end effectors **200**E**1'** and **200**E**2'**, respectively. End effectors **200**E**1'**, **200**E**2'** fit in the cutout region **252** of end effector **250**E'. Optionally, a layer of material may be mounted in instrument **250'** (not shown in FIGS. **5**M-**5**R, but like that shown in FIG. **5**G) to wrap around from the operational surface of end effector **250**E**1'** to the operational surface of end effector **250**E**2'** (see FIG. **5**G) and to overlie the locations of the operational surfaces where the piercing members/suture drivers are driven out from, as well as the locations where the suture anchors are removably mounted. By mounting as described, the piercing members/suture drivers **102'** are aligned with slots **200**S so that they can be rotationally driven out of end effector **250**E**1'**, through tissues **3** (and optionally material **230**) and into end effector **250**E**2'** where sutures **104** are anchored to anchors **106'** via suture mate **108'** in much the same manner as described above with regard to FIGS. **5**H-**5**I except that the driving is rotational rather than linear. This permits the end effectors to be made more compact and able to be delivered through relatively smaller ports. FIGS. **5**Q-**5**R schematically illustrate (distal end schematic representation and perspective schematic representation, respectively) piercing members/suture drivers **102'** (preferably curved needles, but could alternately be screw drives or other elongated members configured to temporarily attach attachment members/sutures to and to drive through the stomach tissues) are deployed from end effector **250**E**1'** to drive attachment members/sutures **104** through the stomach tissues **3** (and, optionally, material **230**). Instrument **250'** is operated to attach the folded tissue surfaces of the stomach **3** together in serosa-to-serosa contact to hold the plication. At the same time the layer of material **230**, if used, is loosely attached to the plication. Material **230** forms a barrier layer that spans the suture line to prevent herniation of the plicated stomach in between the attachment members/sutures, thereby greatly reducing the risk of ischemia. The barrier material may be a sheet or strip of silicone, with or without mesh reinforcement, for example. Whether or not reinforced, the exterior of the strip is silicone, to prevent tissue ingrowth. By preventing tissue ingrowth, this will facilitate reversal of the procedure/plication as the silicone strip will be easily removable.

Suture anchors **106'** are removably held in end effector **250**E**2'** and are aligned with the piercing members/suture drivers **102'**. Attachment members/sutures **104** are releasably engaged with piercing members/suture drivers **102'**. Upon withdrawal of the piercing members/suture drivers, the proxi-

mal ends of the suture mates are retained by the anchors **106'** and the suture mates **108'** slide off the piercing members/suture drivers **102**, thereby leaving the suture mates **108'** and attachment members/sutures **104** installed through the tissues and optionally, the material **230**. It is noted here that if the optional rotation is performed in FIG. **5**F', then the instrument(s) is/are counter-rotated by the amount about the longitudinal axis thereof, to return the stomach **3** to the orientation shown in FIG. **5**G, FIG. **5**H, FIG. **5**I or FIG. **5**J, after performing the procedures described above in FIG. **5**N or after performing the procedures described above in FIG. **5**P, or after performing the procedures described above in FIG. **5**R, or after performing the procedures described above like in FIG. **5**J.

Attachment members/sutures **104** are also pre-installed through suture locks **110** (like those shown in FIGS. **5**I-**5**J) that are removably mounted on end effector **250**E**1'** and are mounted on attachment members/sutures **104** proximal to the piercing members/suture drivers **102'**. Once the attachment members/sutures have been driven and anchored as illustrated in FIG. **5**R and the stomach **3** has been rotated back to its original orientation, if applicable, instruments **250'** and **200'** are removed from the patient, leaving the attachment members/sutures **104**, suture locks **110**, (optionally, material **230**), suture anchors **106'** and suture anchor mates **108'** in place like what is shown in FIG. **5**J. Suture locks **110** have a one-way locking mechanism, such as a ratcheting type mechanism or other arrangement such as directionally oriented teeth that allow suture **104** to be pulled proximally therethrough, but which prevent attachment members/sutures **104** from backsliding distally therethrough. Like shown in FIG. **5**K, the attachment members/sutures **104** are cinched by pulling them proximally relative to the suture locks **110** until a desired amount of tension is developed in the attachment members/sutures **104**, as described previously. Cinching can be performed by the use of laparoscopic graspers (not shown), for example. The bougie **50** can then be removed from the patient and the patient can be closed, according to known techniques, to complete the procedure.

As a further option, an expandable implant **10** may be implanted to fill the inside of the plication **3**PL in a manner like that shown in FIG. **5**L. The implant **10** may be a silicone bladder, for example, capable of being inflated by biocompatible fluid such as liquid, gas, or a combination of fluids (gases, liquids, or liquids and gases). Implant **10** is connected via fill tubing **12** in fluid communication with a subcutaneous fill port **80**, so that the fill volume of implant **10** can be adjusted after implanting it as described from a location outside of the abdominal cavity (e.g., by an operator accessing the subcutaneous fill port **80** with a needle alone or a needle attached to a pressurized source of fluid). Other implants **10** may be substituted, but need to be expandable and are preferably controllable as to amount of expansion. A tab or wing **11**, **11'**, **11"**, **11"'** may be provided to extend from the expandable body of the implant **10** and can be inserted between the tissue folds at the plication suture line so that the attachment members/sutures **104** are also installed through the tab or wing **11**, **11'**, **11"**, **11"'** to thereby securely hold the implant in place, like that illustrated in FIG. **5**L. The tab or wing **11**, **11'**, **11"**, **11"'** may be made of a mesh-reinforced silicone, for example. Alternatively, the implant **10** may be fixed in place by connecting only to the superior and inferior ends of the plication suture line, or by connecting to one or more of the suture locks **110** and/or suture anchors **106**.

An alternative embodiment to those shown in FIGS. **5**M-**5**R is one where the device **250'** deploys a continuous suture instead of multiple interrupted sutures. In this embodiment, the device **250'** would deploy a needle driver that moves from one suture slot **200**S to the next, through a helical motion or through a series of alternating rotation and advancing motions. This method of suturing would result in a continuous suture that penetrated the stomach tissue at each location inside the slots **200**S.

Another alternative embodiment to those shown in FIGS. **5**M-**5**R is one where the suction and suturing functionalities of the two instruments are combined into one instrument. This embodiment would be similar to the embodiment of FIGS. **2**D-**2**H in that the suction and suturing functionalities are provided in a single instrument. However, this embodiment may also be similar to those of FIGS. **5**M-**5**R in that it may utilize needles that have a curved shape, rather than the straight needles shown in FIGS. **2**D-**2**H. In this manner, the curved needles may be housed within the upper end effector, with the suture anchors **106** being housed in the lower end effector. The suction features would be present in both the upper and lower end effectors. As described for FIGS. **2**D-**2**H, the end effectors would close onto the stomach, grip the stomach with suction, open and spread the walls of the stomach, imbricate the stomach and close. At this point, the curved needles would advance through the tissue, being driven by a cam mechanism, a gear, or another driving mechanism. The needles would rotate so that their curved shapes advance through the stomach tissue, engaging the suture anchor mates **108** with the suture anchors **106** housed in the lower end effector. This embodiment may have an advantage over that of FIGS. **2**D-**2**H because the curved shape of the needles, with the rotating advancement, may enable the suturing functionality to be miniaturized into a smaller end effector **9** as compared to the straight needles of FIGS. **2**D-**2**H), which can be used through a smaller surgical port. This embodiment may have an advantage over the embodiments of FIGS. **5***m*-**5**R because it can be used through a single surgical port instead of two ports.

FIG. **6** is a partial perspective view of a bougie **50'** that can be used in any of the procedures described herein that employ bougie **50**, alternatively to the use of bougie **50**, according to an embodiment of the present invention. Bougie **50'** has the same outside diameter as that of bougie **50**, typically 32 French, but could vary, in the same manner described above with regard to bougie **50**. Bougie **50'** is provided with a round cross-section and is flexible in bending along its length, but relatively rigid under compression along its longitudinal direction which facilitated insertion through the esophagus and into the stomach. Bougie **50'** is provided with a blunt, atraumatic distal tip **52** with bluntness provided by the curvature of the distal end of the tip **52**. Bougie **50'** includes an elongated, flexible tube **54** that has a flexible portion at least its distal end portion (excluding distal tip **532**), which flexible portion is long enough to extend out of the mouth of the patient when the bougie **50'** has been placed in its intended operative location (e.g., when tip **52** is at the location of the pylorus as described above). when in an unreinforced configuration, as illustrated in FIG. **1**A. Tube **54** may be formed of polyvinyl chloride (PVC) to ensure that the tube is transparent for maximizing visualization via an endoscope **33** that is insertable therein (shown in phantom in FIG. **6**). Alternatively, polyethylene, polyurethane, PEBAX or MILIFLEX® (thermoplastic elastomer, thermoplastic olefin, Melitek, Dusseldorf, Germany) may be used. Optionally a proximal portion **56** that remains outside of the patient during use may be made stiff or relatively rigid to aid in manipulation of the bougie **50'**.

One advantage of this embodiment is that a flexible endoscope **33** can be inserted into bougie **50'** to provide visibility

to a user outside the patient, through the clear walls of tube **54** and tip **52**. Flexible endoscope **33** can be advanced up into the flexible distal portion of bougie **50'** to provide views along a curved pathway of a tract in the stomach being formed by a procedure according to an embodiment of the present invention. Thus bougie **50'** enables appropriate sizing of the stomach lumen formed during a plication procedure. Additionally, visualization can be performed through the clear side walls and tip of bougie **50'** to inspect the sizing of the stomach lumen and/or various intermediate stages of performing the plication, from a location inside the stomach **30**. Further details about various embodiment of bougie **50'** can be found in co-pending application Ser. No. 12/474,118 filed May 28, 2009 and titled "Devices, Systems and methods for Minimally Invasive Abdominal Surgical Procedures", which application is hereby incorporated herein, in its entirety, by reference thereto.

Referring now to FIGS. **7**A-**7**I, various events are illustrated for the performance of a procedure in which a device **10** is implanted within plications formed at external locations of the stomach. The procedure shown in FIGS. **7**A-**7**I is a laparoscopic procedure in which ports are installed in a patient for access to the abdominal cavity by not only the instrument shown, but also by other instruments typically used in laparoscopic surgery, such as graspers, endoscope, etc.

After establishing ports/pathway into the abdominal cavity from outside the patient, the omentum **5** and connective tissues are dissected at the greater curve of the stomach to provide access thereto, see FIGS. **7**A-**7**B. A bougie **50** is inserted trans-esophageally and placed in the stomach **3** in a position such as shown in FIG. **7**C. Typically the bougie occupies a pathway extending naturally from the esophagus, through the stomach **3** and into the pylorus **3**P, so as to occupy a space similar to what is defined when a sleeve gastrectomy is performed. The bougie acts as a guide so as to better standardize the sizes and locations of plications formed by the procedure as well as to prevent reducing the stomach too aggressively, so as to ensure no blockage locations are inadvertently formed.

An attachment instrument **300** is inserted into the abdominal cavity and an end effector **300**E formed on a distal end of the instrument **300** and having an implantable device **10** releasably mounted thereto, is contacted to the stomach **3** in a manner as illustrated in FIG. **7**D, such that the device **10** contacts the external wall of the stomach **3** and is positioned between the stomach **3** and the end effector **300**E. As shown in FIG. **7**D, the end effector is oriented so that the device **10** primarily contacts the body **3**B and fundus **3**F of the stomach, while the bougie **50** helps insure that the cardia **3**C, pylorus **3**P and pyloric antrum **3**PA remain open so as to avoid risk of forming blockages. Once the end effector **300**E has been oriented so that it is substantially aligned with the central, substantially straight section of the bougie **50** (see FIG. **7**D), tissue pins **302** are deployed so as to extend from the surface of the end effector **300**E as shown in FIG. **7**E.

Next, at FIG. **7**F, graspers are used to grasp portions of the stomach **3** and fold the portions over each side of the end effector **300**E, pushing the stomach plications **3**PL onto the tissue pins **302** so as to temporarily hold the plications **3**PL in the positions shown in FIG. **7**F. At FIG. **7**G, a strap **304** of the attachment instrument **300** is inserted through the same port that the end effector **300**E was inserted through. The distal end portion **304**D of the strap **304** is connected to the distal and proximal ends of the end effector **300**E. The strap **304** is mounted on a stiff paddle and the paddle is used to hold the strap **304** in place in compression against the stomach plications **3**PL as shown. The paddle includes a proximal handle **304**H that extends out of the patient and is used by the operator to manually adjust the clamping force of the strap onto the tissue so as to hold the tissue of the plications **3**PL in tight approximation to the end effector **300**E. Stitching needles are then deployed from the end effector **300**E to penetrate the double walls of the stomach plications **3**PL and connect suture bullets (described below) to anchors **32** (such as speed nuts, traps or other features that are directly connectable to the suture bullets). The opposite ends of the attachment members/sutures **30** are pre-fixed to a layer of material **12** that encourage tissue ingrowth and is also fixed to the expandable device **10**, see FIG. **7**I. For example, the tissue ingrowth encouraging material may be a porous mesh of biocompatible material such as DACRON® (polyester) or other fabrics that are known in the art to encourage tissue ingrowth. The attachment members/sutures are tightened and bougie **50** and attachment instrument **300** (including the strap **304** are removed, as shown in FIG. **7**H, leaving the device **10** in place, maintained in positioning by the plications (see FIG. **7**H) which are sutured to the device **10** via attachment members/sutures **30**, see FIG. **7**I. The plications **3**PL preferably abut one another in serosa-to-serosa contact as illustrated by **3**S**2**S in FIGS. **7**H-**7**I. The space left by removal of the end effector **300**E provides room for the device **10** to expand into. As shown in the cross-section illustration of FIG. **7**I, device **10** can then be expanded/inflated to further reduce the amount of space in the interior cavity of the stomach **3**. The sleeve volume gauged by placement of the bougie **50** during the procedure can be adjusted by adjusting the volume of the device **10**. The fill tube **12** is connected to an access device which can be implanted outside the abdominal cavity, against the external abdominal wall or fascia, for example, as described in application Ser. Nos. 11/407,701; 11/881,144; 10/567,199; 11/974,444; 11/716,985; 11/716,986; 12/473,818; 12/473,881; 12/474,118; 12/474,070; 12/474,087; 12/474,158; 12/474,234; 12/474,251; 12/474,253; 12/474,226; and 13/015,086, each of which is hereby incorporated herein, in its entirety, by reference thereto.

The implantable devices described herein are preferably cylindrical shaped, so as to form a rod or hot-dog-like appearance, but could be of another shape, including, but not limited to a curved, cylindrical shape not unlike the shape of a banana. The devices are expandable, typically by input of a pressurized fluid, such as saline or other biocompatible liquid, biocompatible gas, or a combination of biocompatible gas and liquid.

FIG. **8**A is a perspective view of another embodiment of an attachment instrument according to the present invention, configured to be operated from outside of a patient, with the end effector having been inserted through a laparoscopic port or percutaneous opening and into contact with the patient's stomach **3** (e.g., into the abdominal cavity of the patient), and to reduce the effective volume of the stomach **3** by performing one or more plication procedures on it.

Attachment instrument **400** includes an elongate end effector **400**E having a length **400**L greater than a width **400**W (typically at least more than twice as great) formed at a distal end portion of instrument **400**. End effector **400**E includes a distal end **400**D, a proximal end **400**P and first and second sides **400**S. An elongate shaft **420** extends proximally from the proximal end **400**P of end effector **400**E. Shaft **420** has sufficient length so that a proximal end of the shaft **420** extends out of the patient's body when the end effector **400**E is placed on the patient's stomach in a manner described below and shown in FIG. **8**D.

A plurality of piercing members **102** (typically suture drivers such as stitching needles or the like) are positioned along

a pair of rows extending lengthwise along the end effector **400**E, one row along each side **400**S (e.g., see sectional illustration of FIG. **8**N). A portion of a row is shown in the enlarged partial view of FIG. **8**O that shows three piercing members **102**.

A plurality of attachment members **104** extend along a pair of rows extending lengthwise along the end effector **400**E, see FIGS. **8**B, **8**F, **8**I, **8**J, **8**M and **8**O. The attachment members shown in this embodiment are attachment members/sutures **104** and are arranged, configured and positioned to be driven through a fold in the stomach **3**.

A lower contact plate **402** is spaced beneath and parallel with an upper tissue contact surface **404** of the end effector **400**E, forming a gap **400**G between plate **402** and surface **404** as shown in FIG. **8**B. A driving mechanism **410** is provided which is configured to drive folds of stomach tissue into the gap **400**G between plate **402** and surface **404**. As shown in FIGS. **8**A, **8**B and **8**E, driving mechanism **410** includes a pair of mechanisms, one on each side, each including a pair of textured roller bars **412**, gears configured for selectively operating a single roller **412** or the pair of roller bars in linked unison, and a driver **416**, which may be hand operation of one or more shafts extending proximally from the gears or one or more motors for operating the roller bars **412**. The roller bars **412** extend lengthwise along the end effector **400**E, one alongside surface **404** and one alongside plate **402** and, when operated, are rotated counter to each other so as to either pull tissue in between the bars **412** or eject tissue out from the gap **400**G between the bars. The opposite side **400**S is configured with a mechanism that is the same as that described and shown in FIG. **8**B. The pair of mechanisms typically operate the pairs of rollers **412** on opposite sides independently of each other. Optionally, the mechanisms may be selectively linked to control both sets of rollers to perform the same operation simultaneously (taking tissue in or driving tissue out).

A handle **430** is connected to a proximal end portion of shaft **420**. Shaft **420** has a length sufficient to allow a user to operate the controls on handle **430** (and the drive shafts **417** at least when the driver **416** is hand operation) from a location outside of an obese or overweight patient when the end effector **400**E has been contacted to the stomach in a manner as shown in FIG. **8**D. Handle **430** includes an axial portion **430**A and a transverse portion **430**T, see FIGS. **8**A and **8**C. These portions are configured so that the user can apply both hands to the handle **430** if desired and, by pushing on handle portion **430**T and pulling up on handle portion **430**A can apply a force to the end effector **400**E to press it down against an external surface of the stomach **3** where the plication procedure is to be performed. Plate **402** is biased away from surface **404** such as by coil springs **422** or the like, so that gap **400**G is maintained until actuator **440** is engaged (such as by pressing with the thumb, in the embodiment shown), which causes plate **402** and surface **404** to be driven closer together, so as to clamp down on stomach tissues after the stomach tissues have been drawn into the gap **400**G sufficiently.

After preparing the patient, inserting a bougie **50**, **50'** into the stomach **3** in a manner as described above and forming either a percutaneous opening (e.g., puncture and opening leading from puncture into the abdominal cavity, for a percutaneous procedure) or a plurality of ports for a laparoscopic procedure, end effector **400**E of instrument **400** is inserted through the puncture or one of the ports and delivered into the abdominal cavity, where it is placed into contact with an exterior surface of the stomach **3** as shown in FIG. **8**D. Typically, the end effector is substantially aligned with the bougie **50**, **50'** adjacent to the bougie **50**, **50'** on a location of the stomach nearer to the greater curvature **3**G or on the greater curvature **3**G with the bougie **50**, **50'** being nearer the lesser curvature **3**L as shown. End effector **400**E preferably contacts the stomach **3** in an inferior to superior direction extending substantially over the body **3**B and fundus **3**F, but not over or in contact with the pylorus **3**P, pyloric antrum **3**PA, cardia **3**C or gastroesophageal junction **3**GE.

Once the end effector **400**E has been properly positioned as intended and contacted to the stomach **3**, as illustrated in the schematic cross-sectional view of FIG. **8**E, the bougie **50**, **50'** is removed from the patient and the roller bars **412** are operated by operating the driving mechanisms to draw stomach tissue into the gap **400**G on both sides **400**S of the end effector as illustrated in FIGS. **8**F-**8**G. Optionally, conventional laparoscopic graspers can be used to initially feed the stomach tissue into the gap. The plications of tissue formed are pulled over the lower roller bars **412** and under the upper roller bars **412** as shown best in the schematic, cross-sectional illustration of FIG. **8**G. Vacuum tubes **442** are provided that extend along the upper surface of base **402** and are provided with ports or openings at intervals along the lengths thereof. Vacuum tubes **442** extend parallel to roller bars and to each other, but are located adjacent to the central longitudinal axis of base **402** as illustrated in FIG. **8**G. Preferably, a pair of vacuum tubes **442** are provided, one on each side of the central longitudinal axis as shown, although more or fewer vacuum tubes **442** may be employed. Vacuum delivered through the openings/ports of the vacuum tubes **442** hold the plicated tissues in contact therewith once the plicated tissues have been drawn/driven into contact therewith by the driving mechanism. Vacuum tubes **442** may additionally assist in drawing the tissues into the final positions shown in FIG. **8**G. As noted previously, the operator can turn the roller bars **412** to draw stomach tissue into the positions shown in FIG. **8**G in preparation for stitching. The bars **412** are textured or provided with other features to assist gripping the stomach tissue. The bars **412** can be rolled together or individually, in order to provide greater control over how the tissue is drawn into the gap **400**G.

At this time, the operator operates actuator **440** to clamp the stomach tissue in the end effector **400**E. In the unactuated position of actuator **440** shown on the left side of FIG. **8**H, the gap **400**G is in its biased open position as illustrated in FIG. **8**I. Upon operating the actuator **440** to the actuated position shown on the right side of FIG. **8**H, the plate **402** and surface **404** are brought closer together, thereby clamping the tissue in accordance with the force arrows shown in FIG. **8**J.

Once the stomach tissues have been clamped as described above, stitching actuator **442** is next actuated to drive piercing members **102** and attachment members **104** through the stomach tissues as illustrated in FIGS. **8**M, **8**N and **8**O. Piercing members **102** are preferably needles, but could alternately be screw drives or other elongated members configured to temporarily attach attachment members thereto and to drive through the stomach tissues. Attachment members **104** are preferably sutures, but could alternatively be ribbons or other attachment members configured to perform as described, or hybrids thereof. Suture anchors **106** (best shown in FIG. **8**B) are removably held in plate **402** and are aligned with the piercing members/suture drivers **102**. Attachment members (which are sutures, in the embodiment shown) **104** are releasably engaged with piercing members **102**. In the embodiment shown in FIG. **8**O, attachment members/sutures **104** are each provided with an anchor mate **108** on a distal end portion thereof, preferably at the distal end thereof. Anchor mate **108** is configured to slide over the tapered distal end portion of the suture driver/stitching needle **102**, but is prevented from slid-

ing further proximally by the increasing diameter of the taper of the driver/needle **102** distal end portion. The exterior of the anchor mate **108** is also tapered, so that the distal end **108**D thereof is of a smaller cross-sectional dimension than the proximal end **108**P thereof. This facilitates the driving of the anchor mate **108** into the anchor **106** as shown in FIG. **8**N. However, upon withdrawal of the piercing member **102**, the proximal end of the anchor mate **108**P is retained by the anchor **106** and the anchor mate **108** slides off the piercing member/suture driver **102**, thereby leaving the anchor mate **108** and suture **104** installed through the tissues as illustrated in FIG. **8**P. In the embodiment shown, actuator **442** is biased to the position shown at the top of FIG. **8**L and functions as a ratchet during actuation such that cycling the actuator between the position shown at the top and the position shown at the bottom of FIG. **8**I incrementally drives the piercing members **102**, anchor mates **108** and attachment members **104** through the tissues and into the anchors **106** where anchors **106** and attachment members **104** are retained. Continued cycling retracts the piercing members **102** back into the main body of the end effector **400**E into the stowed positions were they are concealed.

The end effector **400**E is then removed by sliding it out of the attached tissues, whereby anchors **106** release from plate **402**, leaving anchor mates **108**, and therefore also attachment members/sutures **104** in retention by anchors **106** as shown in FIG. **8**P. Attachment members/sutures **104** are also pre-installed through suture locks **110** that are attached to a conjunction member **460**. In the embodiment shown in FIG. **8**P, side by side pairs of sutures are preinstalled through suture locks, respectively (although other alternative arrangements may be substituted, including, but not limited to providing a suture lock **110** for each suture **104** as illustrated in the variant shown in the cross-sectional illustration of FIG. **8**S) and conjunction member **460** is provided as a strip of material having sufficient length and width to cover the plication line **3**PL formed by the abutment of the two tissue folds of stomach. Conjunction member **460** is configured as a porous material on the side **460**B facing the plication line **3**PL (see FIG. **8**Q). The porous material is a tissue ingrowth material that may be made of any of the same materials mentioned above with regard to tissue ingrowth materials and/or any known biocompatible tissue ingrowth materials suitable for accomplishing the tasks described. The opposite side **460**T of the conjunction member, which faces away from the plication line **3**PL (see FIG. **8**P) is nonporous to prevent tissue ingrowth therein. For example, the top surface **460**T of **460** in FIG. **8**P may be formed or coated with silicone or other nonporous biocompatible substance to prevent tissue ingrowth into the top surface of the conjunction member **460**.

Suture locks **110** have a one-way locking mechanism per each attachment member/suture **104** inserted therethrough, such as a ratcheting type mechanism or other arrangement such as directionally oriented teeth that allow attachment member/suture **104** to be pulled proximally therethrough, but which prevent attachment members/sutures **104** from backsliding distally therethrough. FIGS. **8**R and **8**S illustrate the pulling of attachment members/sutures **104** in tension in the directions indicated by the arrows, so that they slide proximally relative to suture locks **110**, thereby cinching the attachment members **104** tight under tension and bringing the conjunction member **460** into contact with the stomach tissues so as to overlie the plication line **3**PL as illustrated in FIG. **8**R. As a result, the folds of the two plications are drawn into abutment if they were not already in abutment, and the plication line **3**PL is maintained with the folds in abutment, in serosa-to-serosa contact, by anchors **106** and anchor mates **108** underneath and conjunction member **460** and suture locks **110** on top, interconnected under tension by attachment members/sutures **104**. Because the width of the conjunction member **460** and especially the width of the suture lock **110** or side by side pair of suture locks is less than the width **106**W of the original spacing between anchors **106** (see FIG. **8**P), the cinching of the attachment members/sutures **104** described above causes the stomach tissue to be drawn toward the center line, driving the opposing tissue folds together in abutment, providing serosa-to-serosa contact which eventually adhere to each other and grow together. The outer surfaces of the stomach contacting surface **460**B will also grow into the tissue ingrowth material thereof. These two tissue joints (serosa-to-serosa adhesion and tissue ingrowth into the mesh **460**B) provide long term attachment that maintains the plication in the configuration illustrated in FIGS. **8**R and **8**S.

FIG. **9** is a schematic illustration of an alternative mechanism for making a stitch (or simultaneous stitches) through tissue that is applicable to stitching a plication line PL according to another embodiment of the present invention. In this embodiment, piercing members/stitching needles **102** are rotationally driven out of the surface of the end effector **400**E' through tissue and into engagement with an attachment member/suture anchor **106**. Tissue pins/stabilizing pins are deployed at step **9**A so as to temporarily hold the tissue in place during the stitching procedure. At **9**B, deployment of the piercing members/stitching needles **102** from the surface of the end effector **400**E' is begun, such as by use of an actuator like **442** described in regard to FIG. **8**A, although not shown here. Further details about the structure and functioning of driving mechanisms and other components of this embodiment can be found in co-pending application Ser. No. 12/474,226, which has already been incorporated herein, in its entirety, by reference thereto above. At **9**B the piercing members/stitching needles **102** are shown in an early stage of deployment of the process, e.g., after only one or two pulls of the actuator **4172**. Note that the locations where the members/needles **102** pierce into the tissue **3** are substantially aligned with the locations where the corresponding stabilizing pins/tissue pins **302** pierce into the target. In the embodiment shown, the tip of the needle **102** is aligned axially (i.e., at the same length along the proximal-distal axis of the stitching instrument, i.e., the left-right direction in **9**B) with the tip of the stabilizing pin **302**, when both are in their starting positions, ready to pierce into tissue **5**. Also, pins **302** are angled in a direction opposite to a direction toward which the stitching needles **102** are angled, relative to the surface of the tissue **3**, as they enter the tissue **3**. In this way, the stabilizing pins/tissue pins **302** provide counter-traction and prevent the tissue **3** from being dragged or bunched up or pushed away by the stitching needles **102** as they sweep through the tissue **3**, being rotated into and then out of the tissue **3**T.

At **9**C, the piercing members/stitching needles **102** have been rotated about halfway through the tissue **3**. Note that the pins **302** remain in position as originally deployed. The piercing members/stitching needles **102** have been rotated in **9**D to the extent where the tips of the needles **102** have emerged back out of the tissue **3**. Like the tissue pins/stabilizing pins, the needles **102** may pass all the way through the tissue **3** (phantom lines) or may rather be inserted into the tissue **3**, rotated through the tissue **3** without ever passing through a back side of the tissue **3**, and pass back out of tissue **3** at another location (exit location) different from the entry location, but located on the same surface of the target. This is preferred for serosa-to-serosa stitching where it is desirable not to pass into the mucosa or interior of the stomach, but only through the serosa **3**S and muscularis **3**M layers. **9**E illus-

trates the needles **102** having been rotated to the extent where the tips of the needles **102** and the anchor mates **108** have been driven through the respective attachment member/suture anchors **106**. Upon counter-rotation of the needles **102**, the tips of the needles **102** slide out of contact with the anchor mates **108** and pass back out of the attachment member/suture anchors **106**, while the attachment member/suture anchors **106** retain the anchor mates **108** and prevent them from passing back through, thereby securing the attachment members/sutures **104** to the attachment member/suture anchors **106**.

Upon anchoring the attachment members/sutures **104** to the anchors **106** as described above and when the piercing members/stitching needles **102** have been fully returned to their concealed positions in the end effector **400**E', the tissue/stabilizing pins **302** can be retracted into their concealed positions within the end effector **400**E'.

Instrument **400'** can therefore be used to perform a method for decreasing the effective volume of a patient's stomach, to include contacting a length end effector **400**E' to an external surface of the stomach **3**; forming a fold in the stomach and positioning the fold over a portion of the end effector; deploying the tissue/stabilizer pins **302** to temporarily hold the fold of tissue in place on the end effector **400**E'; and simultaneously driving a plurality of attachment members **102** through the fold, wherein the attachment members are configured along a length direction relative to the end effector **400**E'. Optionally, a device **10** of any of the types described above could be installed between an external surface of the stomach and the fold using the end effector **400**E' and/or other instrument. The instrument **400'** can be used to place a row of stitches in a single deployment as described above to make a plication and a reduced volume sleeve in the stomach, or can be used multiple times to perform multiple deployments to form a sleeve in the stomach by installing multiple lines of stitches. In this and all other embodiments employing one or more attachment members/sutures **104**, the attachment members/sutures **104** may be sutures and may be connected at their distal ends to anchor mates **108** as described above, which anchor mates **108** may be made of plastic or metal. Alternatively, in addition to the alternatives already previously noted, attachment member/suture **104** may be a metal wire or lead configured to connect with anchor **106**, and these metal wires or leads may be similarly connected to metal or plastic anchor mates **108**. Metal wire or lead **104** may or may not be electrically conductive.

Instrument **400'** may alternatively be used intralumenally to stitch a plication inside the stomach **3** by driving the needles **102** through mucosa and back out of mucosa, after passing through one or more additional layers of the stomach wall. Thus full penetration or partial penetration of the stomach wall may be performed during stitching.

FIGS. **10**A-**10**J illustrate various events for the performance of a procedure in which a device **10** is implanted within plications formed at external locations of the stomach **3** according to an embodiment of the present invention. The procedure shown in FIGS. **10**A-**10**J is a laparoscopic procedure in which ports are installed in a patient for access to the abdominal cavity by not only the instrument shown, but also by other instruments typically used in laparoscopic surgery, such as graspers, endoscope, etc.

After establishing ports/pathway into the abdominal cavity from outside the patient, the omentum **5** and connective tissues are dissected at the greater curve of the stomach to provide access thereto, the same as described above with regard to FIGS. **7**A-**7**B. A bougie **50**, **50'** is inserted transesophageally and placed in the stomach **3** in a position such as shown in FIG. **10**A. Typically the bougie **50**, **50'** occupies a pathway extending naturally from the esophagus, through the stomach **3** and into the pylorus **3**P, so as to occupy a space similar to what is defined when a sleeve gastrectomy is performed. The bougie acts as a guide so as to better standardize the sizes and locations of plications formed by the procedure as well as to prevent reducing the stomach **3** too aggressively, so as to ensure no blockage locations are inadvertently formed.

An attachment instrument **300'** is inserted into the abdominal cavity and an end effector **300**E' formed on a distal end of the instrument **300'** and having an implantable device **10** releasably mounted thereto, is contacted to the stomach **3** in a manner as illustrated in FIG. **10**A, such that the device **10** contacts the external wall of the stomach **3** and is positioned between the stomach **3** and the end effector **300**E'. As shown in FIG. **10**A, the end effector **300**E' is oriented so that the device **10** primarily contacts the body **3**B and fundus **3**F of the stomach, while the bougie **50**, **50'** helps insure that the cardia **3**C, pylorus **3**P and pyloric antrum **3**PA remain open so as to avoid risk of forming blockages. Once the end effector **300**E' has been oriented so that it is substantially aligned with the central, substantially straight section of the bougie **50**, **50'** (see FIG. **10**A), tissue pins/stabilizer pins **302** are deployed so as to extend from the surface of the end effector **300**E' as shown in FIG. **10**B.

Next, at FIG. **10**C, graspers or other instrument are used to grasp portions of the stomach **3** and fold the portions over each side of the end effector **300**E', pushing the stomach plications **3**PL onto the tissue pins **302** so as to temporarily hold the plications **3**PL in the positions shown in FIG. **10**C. At FIG. **10**D, conjunction member **460** is placed over the line where the plications **3**PL join one another, to cover the junction line. This placement may be performed using graspers for example, or other instrument(s). In the embodiment shown in FIG. **10**D, conjunction member **460** is provided as a strip of material having sufficient length and width to cover the plication line **3**PL formed by the abutment of the two tissue folds of stomach. Conjunction member **460** is configured as a porous material on the side in contact with the stomach tissues and plication line **3**PL (see FIG. **10**D). The porous material is a tissue ingrowth material that may be made of any of the same materials mentioned above with regard to tissue ingrowth materials and/or any known biocompatible tissue ingrowth materials suitable for accomplishing the tasks described. The opposite side **460**T of the conjunction member **460**, which faces away from the plication line **3**PL (see FIG. **10**D) is nonporous to prevent tissue ingrowth therein. For example, the top surface **460**T of **460** in FIG. **10**D may be formed or coated with silicone or other nonporous biocompatible substance to prevent tissue ingrowth into the top surface of the conjunction member **460**.

At FIG. **10**E, a strap **304'** of the attachment instrument **300'** is inserted through the same port that the end effector **300**E' was inserted through. The distal end portion **304**D' of the strap **304'** is connected to the distal end portion **300**D' of the end effector **300**E' and the proximal end portion **304**P' is connected to the proximal end portion **300**P' of the end effector **300**E' by means of a paddle that it is connected to. The paddle includes a proximal handle **304**H that extends out of the patient and is used by the operator to manually adjust the clamping force of the strap **304** onto the tissue **3** to hold the conjunction member **460** and tissue **3** in tight approximation to the end effector **300**E'. Piercing members/stitching needles **102'** are then deployed from the end effector **300**E' to penetrate the double walls of the stomach plications **3**PL and the conjunction member **460** and to connect anchors **108'** to the conjunction member **460**, see FIG. **10**F.

In the embodiment shown, piercing members/stitching needles **102'** are configured with a slot **102**S that opens to the distal end of **102'** but is closed at the proximal end of the slot **102**S, see FIG. **10**F'. Attachment members/sutures **104** are attached distally to T-bars **108'** (see FIG. **10**G). T-bar **108'** extends out of slot **1025** when attachment member/suture **104** is preinstalled through the hollow lumen in piercing member/stitching needle **102'**. When piercing members/stitching needles **102'** are deployed, they carry the T-bars **106'** and therefore also attachment members/sutures **104** along with them, as the T-bars stop out against the closed ends of the slots **102**S. The portion of the T-bar that extends out of the slot **102**S is driven through the tissue **3** and conjunction member **460**. When the piercing members/stitching needles **102'** are withdrawn back out of the conjunction member **460** (FIG. **10**G), the extending portions of the T-bars **106'** catch in the mesh of the conjunction member or other part of the conjunction member **460** and are passively deployed out of the needles **102'** thereby anchoring themselves to the conjunction member **460** as illustrated in the sectional view of FIG. **10**J. The opposite ends of the attachment members/sutures **104** are pre-fixed to a layer of material **12** via suture locks **110**. Material **12** encourages tissue ingrowth and is also fixed to the expandable device **10**, see **10**J. For example, the tissue ingrowth encouraging material may be a porous mesh of biocompatible material such as DACRON® (polyester) or other fabrics that are known in the art to encourage tissue ingrowth.

After completely retracting the needles **102'** back into the end effector **300**E' at FIG. **10**G, the tissue pins **302** are retracted at FIG. **10**H and strap **304** is detached and removed from the patient, leaving the conjunction member **460** attached to the tissues **3** as shown in FIG. **10**H. Next, the bougie **50**, **50'** is removed from the stomach **3** and the patient at FIG. **10**I. The sutures **104** can then be cinched down under tension by pulling them through suture locks **110**, and excess suture material can then be trimmed, such as by using a suturing/stitching device as described in application Ser. No. 12/474,226 or by use of graspers, for example. The remaining instruments are then removed and the implant **10** is inflated via inflation tubing **12**. Inflation tubing is then connected in fluid communication with an inflation port that allows changing the volume of the implant from outside of the patient.

FIG. **10**J is a cross-sectional illustration of the result of the procedure described above, with implant **10** having been inflated. The sleeve volume **3**S can be adjusted by adjusting the volume of the implant **10**. The space **300**SP left upon removal of the end effector **300**E' allows for room for the implant **10** to expand into upon further adjustment.

FIGS. **11**A-**11**S illustrate various events for the performance of a procedure in which a device **10** is implanted within plications formed at external locations of the stomach **3** according to an embodiment of the present invention. The procedure shown in FIGS. **11**A-**11**S is a laparoscopic procedure in which ports are installed in a patient for access to the abdominal cavity by not only the instrument shown, but also by other instruments typically used in laparoscopic surgery, such as graspers, endoscope, etc.

After establishing ports/pathway into the abdominal cavity from outside the patient, the omentum **5** and connective tissues are dissected at the greater curve of the stomach to provide access thereto, the same as described above with regard to FIGS. **7**A-**7**B. A bougie **50**, **50'** is inserted transesophageally and placed in the stomach **3** in a position such as shown and described above with regard to FIG. **7**C, for example. Typically the bougie **50**, **50'** occupies a pathway extending naturally from the esophagus, through the stomach **3** and into the pylorus **3**P, so as to occupy a space similar to what is defined when a sleeve gastrectomy is performed. The bougie acts as a guide so as to better standardize the sizes and locations of plications formed by the procedure as well as to prevent reducing the stomach **3** too aggressively, so as to ensure no blockage locations are inadvertently formed.

An attachment instrument **300"**, a distal end portion of which is shown in the isolated view of FIG. **11**A, is inserted into the abdominal cavity and an end effector **300**E" formed on a distal end of the instrument **300"** and having an implantable device **10** releasably mounted thereto, is contacted to the stomach **3** in a manner as illustrated in FIG. **11**B, such that the implantable device **10** contacts the external wall of the stomach **3** and is positioned between the stomach **3** and the end effector **300**E". In this embodiment, instrument **300"** is provided with folding bars **330** that are elongated along the lengthwise direction of end effector **300**E" and preferably extend substantially parallel to the longitudinal axis of the L-L of end effector **300**E". Folding bars are rotationally mounted to instrument **300**E", each bar having a radially extending portion **330**R that is rotationally mounted to the instrument **300"** and from which the main longitudinal portion **330**L extends, as shown in FIGS. **11**A-**11**B. This arrangement allows the longitudinal portions **330**L of the bars **330** to be rotated relative to end effector **300**E" and implant **10** along arcs that are at predetermined distances from the end effector **300**E". As shown in FIG. **11**B and the cross-sectional view of FIG. **11**C, the instrument **300"** and implant **10** are inserted such that folding bars **330** slide under (posterior to) the stomach **3** and implant **10** and end effector **300**E" are contacted to the stomach on top (anterior to) of the stomach. Once the instrument **300"** and implant **10** are contacted to the stomach in the manner desired, with the end effector **300**E" and left folding bar adjacent the bougie **50**, **50'** as illustrated in FIG. **11**C, the folding bars **330** are rotated in opposite directions relative to one another to a level about the same as the level of the end effector **300**E", such that they are side by side with the sides **300**S" of the end effector **300**E", see FIG. **11**D, rather than below the end effector as they were in FIG. **11**C. Alternatively, one bar **330** can be rotated while the other bar **300** remains stationary. The cross-sectional view of FIG. **11**E better illustrates the side by side positioning of the folding bars **330** and end effector **300**E".

The surgeon next uses laparoscopic graspers **332** to manipulate tissue of the stomach **3** by grasping the stomach wall and plicating it into the spaces between the end effector **300**E" and the folding bars **330**, as illustrated in the cross-sectional view of FIG. **11**F. This plicating procedure allows the irregular shape of the stomach to be compensated for, where more plicating is provided at locations that extend further out from the bars **33** and relatively less plicating is performed in regions that extend out less far from the bars **330**. For example, near the fundus **3**F, where there is more stomach tissue, more tissue is plicated into the space **3**SP then the amount that is plicated at the lower main body, nearer the antrum. The goal is to plicate as much stomach tissue inside each gap **3**SP as possible, so that the resulting plications formed will make the outside wall resulting tight. FIG. **11**G illustrates the stomach tissue having been plicated as desired.

At FIG. **11**H the surgeon uses laparoscopic graspers **332** to grasp the stomach wall tissue and pull the outside wall **3** tight around the end effector **300**E" as illustrated in FIG. **11**H and the cross-sectional illustration of FIG. **11**I. A plurality of suction holes or ports **312** are formed in both end effectors **100**E**1**, **100**E**2**. Suction holes/ports **312** are oriented in a pair of rows extending along a length of end effector **300**E", and are in fluid communication with a source of negative pressure

(not shown) provided outside of the patient. For example, a suction line that is in fluid communication with holes/ports **312** may extend proximally therefrom and be configured for connection to a source of negative pressure, such as the suction system of an operating room or other source of negative pressure. These suction holes/ports **312**, upon application of suction therethrough and when tissue **3** is in contact therewith, engaged the end effector **300**E" with the stomach tissue **3** and hold the stomach walls in the folded configurations shown in FIG. **11**H-**11**I, in a pair of plications ready to be finalized by fixing their positions.

Next, a conjunction member (e.g., mesh layer or other tissue ingrowth encouraging material) **460** is placed against the stomach tissue **3** in contact therewith, and spanning the plication line **3**PL between the plications as illustrated in FIGS. **11**J-**11**K. In this embodiment, conjunction member **460** is temporarily mounted in a paddle **460**P. Paddle **460**P has a handle **460**H extending proximally therefrom that a user can operate from outside the patient to engage the paddle **460**P with end effector **300**E" in the manner shown, so as to contact the conjunction member **460** to the stomach **3** tissue as described above. The conjunction member **460** will become attached to the stomach **3**, and the paddle **460**P will release the conjunction member **460** before the paddle **460**P is removed.

At FIG. **11**L piercing members/stitching needles **102'** are deployed from the end effector **300**E" to penetrate the double walls of the stomach plications and the conjunction member **460**, see also, the detail view of FIG. **11**M. As noted above, the application of suction through suction holes/ports **312** maintains the stomach **3** tissues engaged with the end effector **300**E" as the piercing members/stitching needles **102'** penetrate the stomach tissues and conjunction member, as shown in the cross-sectional view of FIG. **11**N.

In the embodiment shown, piercing members/stitching needles **102'** are configured with a slot **102**S (see FIG. **11**M) that opens to the distal end of **102'** but is closed at the proximal end of the slot **102**S. Attachment members/sutures **104** are attached distally to T-bars **108'** (although the T-bars could alternatively be replaced by umbrella-shaped members, grappling hooks, other hook-shaped members, or the like). T-bar **108'** extends out of slot **102**S when attachment member/suture **104** is preinstalled through the hollow lumen in piercing member/stitching needle **102'**. When piercing members/stitching needles **102'** are deployed, they carry the T-bars **108'** and therefore also attachment members/sutures **104** along with them, as the T-bars stop out against the closed ends of the slots **102**S. The portion of the T-bar that extends out of the slot **102**S is driven through the tissue **3** and conjunction member **460**. When the piercing members/stitching needles **102'** are withdrawn back out of the conjunction member **460** (FIG. **11**O), the extending portions of the T-bars **108'** catch in the mesh of the conjunction member **460** or other part of the conjunction member **460** and are passively deployed out of the needles **102'** thereby anchoring themselves to the conjunction member **460** (see also, the sectional view of FIG. **11**Q). At FIG. **11**P, the attachment members/sutures are cinched using a suture tightening device of the instrument **300"** and this pulls the T-bars **108'** tight against the conjunction member **460** as illustrated in FIGS. **11**P-**11**Q.

Next, the bougie **50**, **50'** is removed from the stomach **3** and the patient. The paddle **460**P is detached from the conjunction member **460** and removed from the patient, the attachment portion of instrument **300**E" is removed from the patient, and attachment members/sutures **104** can be cinched again at this time, using the suture tightening device of instrument **300**E" and the excess of the attachment member/sutures **104** resulting from cinching are also trimmed, using the suture tightening portion of instrument **300"**. The suture tightening portion is also removed, and the implant **10** is inflated leaving the result shown in FIGS. **11**R-**11**S. Inflation tubing **12** is then connected in fluid communication with an inflation port that allows changing the volume of the implant **10** from outside of the patient.

FIG. **11**S is a cross-sectional illustration of the result of the procedure described above, with implant **10** having been inflated. The sleeve volume **3**S can be adjusted by adjusting the volume of the implant **10**. The space **300**SP left upon removal of the end effector **300**E" allows for room for the implant **10** to expand into upon further adjustment. The ends of the attachment members/sutures **104** opposite the ends fixed to **108'** are pre-fixed to a layer of material **11**, **11'**, **11"**, **11'** via suture locks **110**. Tab **11**, **11'**, **11"**, **11'** encourages tissue ingrowth and is also fixed to the expandable device **10**, see FIG. **11**S. For example, the tissue ingrowth encouraging material may be a porous mesh of biocompatible material such as DACRON® (polyester) or other fabrics that are known in the art to encourage tissue ingrowth.

The folding bars **330** of this embodiment are shaped to nest tightly with the bougie **50**, **50'** (e.g., see FIG. **11**Q). In at least one embodiment, the folding bar adjacent the bougie **50**, **50'** has a concave surface **330**C to better conform to the bougie **50**, **50'** for tighter nesting therewith, so that the resulting plication can be as tight against the bougie **50**, **50'** as possible. The use of suction to hold the plications in position until they are more permanently attached with the attachment members **104'** avoids potential injury and/or damage to the tissues that may result with alternative features such as needles or clamps.

FIG. **12**A is a perspective view of an end effector **300**E' according to another embodiment of the present invention. End effector **300**E"' can be used alternatively to end effector **300**E, **300**E' or **300**E" in the instruments described above. In this embodiment, piercing members/stitching needles **102"** are rotated about ninety degrees upon storage in the end effector **300**E', relative to the storage positions of the previous embodiments. Thus, piercing members/stitching needles **102"** are stored such that the sharp distal ends thereof point in a direction substantially parallel to the place of the contact surface **300**C' (or arranged more nearly parallel than perpendicular), rather than substantially perpendicular to it (or more nearly perpendicular than parallel), as in the previous embodiments. This allows closer arrangement of piercing members/stitching needles, thereby providing a tighter stitching pattern relative to the previous embodiments. Piercing members/"stitching needles **102**" can be driven by a drive shaft which can apply more torque than the rack and pinion drive system used in the previous embodiments. FIG. **12**B schematically illustrates the stomach **3** tissue being wrapped around the end effector **300**E', and this can be performed according to any of the applicable techniques described above.

Next, at FIG. **12**C, tissue pins/stabilizing pins **302** are deployed so as to temporarily hold the tissue in place during the stitching procedure. At FIG. **12**D, piercing members/stitching needles **102"** are deployed **9**B, from the surface of the end effector **300**E"' is begun, such as by use of an actuator like **442** described in regard to FIG. **8**A, although not shown here. At FIG. **12**D the piercing members/stitching needles **102"** are shown in an early stage of deployment of the process, e.g., after only one or two pulls of the actuator, or after otherwise driving the drive shaft for only a short time. Note that the locations where the members/needles **102"** pierce into the tissue **3** are substantially aligned with the locations where the corresponding stabilizing pins/tissue pins **302**

pierce into the target. In the embodiment shown, the tip of the needle **102** is aligned axially (i.e., at the same length along the proximal-distal axis of the stitching instrument, i.e., the left-right direction in FIG. **12**D) with the tip of the stabilizing pin **302**, when both are in their starting positions, ready to pierce into tissue **3**. Also, pins **302** are angled in a direction opposite to a direction toward which the stitching needles **102** are angled, relative to the surface of the tissue **3**, as they enter the tissue **3**. In this way, the stabilizing pins/tissue pins **302** provide counter-traction and prevent the tissue **3** from being dragged or bunched up or pushed away by the stitching needles **102** as they sweep through the tissue **3**, being rotated into and then out of the tissue.

At FIG. **12**E, the piercing members/stitching needles **102"** have been deployed into the anchors **108**, followed by retraction of the piercing members/stitching needles **102"**, leaving the anchor mates **106** mated with the anchors **108** and the attachment members/sutures therefore also attached to the anchors **106** via anchor mates **108**. The stabilizing/tissue pins **302** are then retracted, and the sutures are tightened, instruments are removed and the implant is inflated, as in any of the applicable manners discussed above, leaving the final result schematically represented in FIG. **12**F.

FIG. **12**G shows an isolated perspective view of end effector **300**E' without the stomach **3** being shown, for clarity of illustration of the tissue/stabilizer pins (shown deployed) and piercing members/stitching needles **102"** (shown partially deployed. FIG. **12**H is an end view of the embodiment of FIG. **12**G and FIG. **12**I is a top view of the embodiment of FIG. **12**G.

FIG. **13**A is a perspective view of an end effector **300**E' according to another embodiment of the present invention. End effector **300**E"' can be used alternatively to end effector **300**E, **300**E', **300**E" or **300**E"' in the instruments described above. In this embodiment, piercing members/stitching needles **102"** are rotated about ninety degrees upon storage in the end effector **300**E', like that described above with regard to end effector **300"**. Additionally, this embodiment is provide with a platform **300**ER that is a separate component of the instrument that slides into place as shown in FIG. **13**D, and on which anchors **108** are temporarily held.

FIG. **13**A schematically illustrates the stomach **3** tissue having been wrapped around the end effector **300**E', and this can be performed according to any of the applicable techniques described above.

Next, at FIG. **13**B, tissue pins/stabilizing pins **302** are deployed so as to temporarily hold the tissue in place during the stitching procedure. At FIG. **13**C, platform **300**ER is slid to its operational position. In the operational position, the operation surface of platform **300**ER is substantially normal to the remainder of the top surface of the end effector **300**E', including the locations from which the piercing members/stitching needles **102"** are deployed, as can be seen in FIGS. **13**C-**13**D. At FIG. **13**D, deployment of piercing members/stitching needles **102"** from the surface of the end effector **300**E"' is begun, such as by use of an actuator like **442** described in regard to FIG. **8**A, although not shown here. At FIG. **13**E, the piercing members/stitching needles **102"** have been deployed into the anchors **108**. Next, the piercing members/stitching needles **102"** are retracted, leaving the anchor mates **106** mated with the anchors **108** and the attachment members/sutures therefore also attached to the anchors **106** via anchor mates **108**. The plate **300**ER is withdrawn back to its non-operational/starting position so that end effector **300**E' again appears as shown in FIG. **13**A. The stabilizing/tissue pins **302** are then retracted, and the sutures are tightened, instruments are removed and the implant **10** is inflated, as in any of the applicable manners discussed above, leaving the final result schematically represented in FIGS. **13**F-**13**G. FIG. **13**F is a perspective schematic view and FIG. **13**G is a schematic top view, showing the attachment members/sutures **104** along the plication line **3**PL.

FIG. **14**A is a perspective view of an end effector **300**E' according to another embodiment of the present invention. End effector **300**E"' can be used alternatively to end effector **300**E, **300**E', **300**E", **300**E"' or **300**E' in the instruments described above. In this embodiment, two sets of piercing members/stitching needles **102"**, are provided, and are rotated about ninety degrees upon storage in the end effector **300**E', like those of end effectors **300**E"' and **300**E'. In this embodiment, one set of piercing members/stitching needles **102"** is deployed from a top (contact) surface of the end effector **300**E', while the second set of piercing members/stitching needles **102"** are deployed from the opposite side of the top (contact) surface of the end effector, see FIG. **14**B. In this way, stabilizer/tissue pins **302** are not needed because the forces of the two sets of piercing members/stitching needles **102"** on the tissues oppose each other and drive the plications together, thereby maintaining the plication as desired during the stitching process.

Alternatively to making a greater curvature plication, or an anterior plication, a plication can be formed posteriorly, or one plication can be formed on the anterior side and another plication can be formed on the posterior side of the stomach **3**. In an embodiment where a plication is formed on the anterior surface and a plication is formed on the posterior surface, this can create a sufficient restriction of the stomach **3** to be effective for weight loss without the need to dissect the blood vessels and connective tissues along the greater curvature **3**G of the stomach **3**, which could reduce the risk of ischemia in the stomach tissues. At least the following embodiment is useful for these alternative procedures. Alternatively, the following embodiment can be used in performing a greater curvature plication, where the blood vessels and connective tissues (e.g., omentum **5**) are dissected to allow for a single, larger plication to be performed.

FIG. **15**A illustrates an instrument **500** that includes suction for holding stomach **3** tissue in place during a plication procedure. Air poppets **502** are aligned inwardly of temporarily held anchors **108** with similar relative positioning to the anchors and suction provided in the embodiment of FIGS. **8**A-**8**N. In the embodiment of FIG. **15**A however, air poppets **502** can be used to individually capture stomach tissue during a plication procedure without losing suction from any of the other poppets **502**. When suction is applied to the poppets **502**, the poppets **502** normally remain closed and therefore do not lose any suction. As can be seen in FIGS. **15**A, **15**B and **15**C, poppets **502** are raised above the main contact surface **504** of instrument **500** and also above the level of the anchors **108**.

Suction is applied through the back ports **506** of the instrument **500**. Back ports **506** are in fluid communication with poppets **502** via conduits (not shown) that extend through the instrument **500**. The poppets are spring loaded to the normal, closed position shown in FIGS. **15**A-**15**C. As stomach **3** wall tissue is pushed down on a poppet **502**, this moves the top part of the poppet downward, thereby opening its suction port. The spring that biases the poppet **502** to the raised, off position is just strong enough to overcome the force of the suction. Therefore when additional force is applied to it, such as the stomach tissue contacting the top of the poppet **502**, this compresses the spring and opens the suction port of the poppet **502**. FIG. **15**C illustrates one of the poppet tops having been removed to show the underlying spring **503** and suction

port **505**. As stomach wall tissue **3** is pushed down on a poppet, like shown in FIG. **15**D, suction is applied to the stomach tissue thereby holding it in place. In the meantime, the other poppets **502** that have not been contacted with tissue stay closed, keeping the suction level constant with no significant loss of suction in the system.

At FIG. **15**E, another portion of stomach wall is pushed down against the next poppet in sequence, thereby attaching that portion of the stomach wall **3**. Again, the poppets **502** that have not been contacted remain closed. Also, the previously attached stomach wall tissue remains engaged by the previously contacted poppet **502**. The process can be repeated in the same manner for all remaining poppet, at which time the stomach plications can be more permanently fixed in placed, such as by suturing or the like.

When performing a stomach plication, a method for maintaining the external wall portions being joined in serosa to serosa contact is important as the healing of the serosa to itself is a means of supporting, strengthening and maintaining the plication in the desired geometry. FIGS. **16**A-**16**D illustrate vacuum tubes **442** that can be employed as a mechanical means of ensuring that the stomach tissue is folded into a desired configuration, and which may be used in embodiment such as that shown in FIG. **8**G or the like. Vacuum tube **442** can be connected to a gauge such as a ball gauge or other type of gauge **443** outside of the patient so that when all of the suction ports of the suction tube are covered by stomach **3** tissue, the pressure in the gauge drops to a suction pressure indicative of such, but if the tissue breaks loose at one or more suction ports, the pressure level rises, indicating that the plication is not in proper position to be sutured. However, with only one vacuum tube **442** and gauge **443**, it is possible that only one side of the plication may be covering the suction ports of the tube **442** thus leading to a false indication that the plication is ready to be sutured when, in reality, one side/fold of the stomach tissue is not properly positioned, and therefore serosa to serosa contact would not result if the plication were to be sutured under these conditions. For example, FIG. **16**A illustrates use of only one tube **442** and gauge **443**. FIG. **16**B shows a possibility, using the arrangement of FIG. **16**A, where the top left side of the stomach **3**TL covers the vacuum holes/ports **112** but it is not in contact with the opposing fold **30**F of the stomach **3**. Likewise the right side fold at **3**RS covers vacuum holes **112** but it is not in contact with the tissue fold on the opposing side at **30**S. **3**I shows the ideal positioning of the stomach folds such that the opposing folds both cover the ports **112** and are in the correct positions for being joined in serosa to serosa contact.

By providing two side-by-side vacuum tubes as illustrated in FIG. **16**C, one vacuum tube **442** and its ports **112** can be dedicated to monitoring the positioning of one fold of stomach tissue, and the adjacent vacuum tube **442** and its ports can be dedicated to monitoring the positioning of the opposite fold of stomach tissue. To further ensure serosa to serosa contact of the opposing folds the vacuum tubes **442** can be provided to be movable relative to on another. Accordingly, in a first, relatively spaced apart position shown in FIG. **16**C, the folds of stomach tissue can be placed over the suction tube **442** and engaged thereby. Once the gauges **443** register that the folds of tissue are properly covering the suction holes/ports **112**, the tubes **442** can then be brought closer together, as illustrated at FIG. **16**D, all the while maintaining the tissue folds in engagement with the tubes **442** via the applied suction force and bringing the tissue folds into serosa to serosa contact at the plication line **3**PL.

FIG. **17**A is a perspective view of another embodiment of an attachment instrument **400"** according to the present invention, configured to be operated from outside of a patient, with the end effector having been inserted through a laparoscopic port or percutaneous opening and into contact with the patient's stomach **3** (e.g., into the abdominal cavity of the patient), and to reduce the effective volume of the stomach **3** by performing one or more plication procedures on it.

Attachment instrument **400"** includes a pair of offset, elongate end effectors **400**E", one being positioned higher than other, but substantially parallel therewith in both length and pitch aspects, each having a length greater than a width (typically at least more than twice as great) formed at a distal end portion of instrument **400"**. End effectors **400**E**1"**, **400**E**2"** each include a distal end **400**D, a proximal end **400**E and first and second sides **400**S. An elongate shaft **420** extends proximally from the proximal ends **400**P of end effectors **400**E**1"**, **400**E**2"**. Shaft **420** has sufficient length so that a proximal end of the shaft **420** extends out of the patient's body when the end effectors are placed on the patient's stomach in a manner described below and illustrated in FIG. **17**B.

A plurality of piercing members **102** (typically suture drivers such as stitching needles or the like) are positioned along a pair of rows extending lengthwise along the end effectors **400**E**1"**, **400**E**2"**, see FIG. **17**B. Lower contact plates **4021**, **4022** are spaced beneath and parallel with an upper tissue contact surface **4041**, **4042** of the end effectors **400**E**1"**, **400**E**2"**, respectively, forming a gap **400**G**1**, **400**G**2** therebetween as shown in FIG. **17**B. A driving mechanism **410** is provided which is configured to drive folds of stomach tissue into the gaps **400**G**1**, **400**G**2** as shown in FIG. **17**B. The driving mechanism can be the same as that described above with regard to the embodiment of FIGS. **8**A-**8**B.

After preparing the patient, inserting a bougie **50**, **50'** into the stomach **3** in a manner as described above and forming either a percutaneous opening (e.g., puncture and opening leading from puncture into the abdominal cavity, for a percutaneous procedure) or a plurality of ports for a laparoscopic procedure, end effectors **400**E**1"**, **400**E**2"** of instrument **400"** are inserted through the puncture or one of the ports and delivered into the abdominal cavity, where they are placed into contact with an exterior surface of the stomach **3**. Typically, the end effectors are substantially aligned with the bougie **50**, **50'** adjacent to the bougie **50**, **50'** on a location of the stomach nearer to the greater curvature **3**G or on the greater curvature **3**G with the bougie **50**, **50'** being nearer the lesser curvature **3**L. End effectors **400**E**1"**, **400**E**2"** preferably contact the stomach **3** in an inferior to superior direction extending substantially over the body **3**B and fundus **3**F, but not over or in contact with the pylorus **3**P, pyloric antrum **3**PA, cardia **3**C or gastroesophageal junction **3**GE.

Once the end effectors **400**E**1"**, **400**E**2"** have been properly positioned as intended and contacted to the stomach **3**, the roller bars **412** are operated by operating the driving mechanisms to draw stomach tissue into the gaps **400**G**1**, **400**G**2** as illustrated in FIG. **17**B. The plications of tissue formed are pulled over the lower roller bars **412** and under the upper roller bars **412**. After the first stitch is completed, rollers **410** gather stomach tissue until a desired amount has been driven through the gap **400**G**2**, see FIG. **17**B. The first stitch is formed along the first side of the instrument, along end effector **400**E**1** and fixes the first fold of tissue, but then the rollers adjacent end effector **400**E**2"** can continue to be operated to increase the amount of stomach tissue rolled through the gap **400**G**2**, see FIG. **17**B-**17**C. The stitches are performed one at a time. A wedge can be pulled proximally with the instrument to push down one suture needle at a time as the wedge passes over them.

Once a satisfactory amount of stomach tissue has been drawn through gap **400**G**2**, the stitches are driven on the second side **400**E**2"** of instrument **400"** to fix the other fold of tissue. A conjunction member **460** can be installed and sutures **104** cinched in the same manner as described above with regard to FIGS. **8**P-**8**S. FIG. **17**D shows instrument **400"** having been removed but sutures **104** not yet having been cinched. FIG. **17**E shows the procedure at the stage where the sutures **104** have been cinched, but not yet trimmed, and where the bougie **50**, **50'** has been removed.

FIGS. **18**A-**18**C illustrate use of a wrapping plication tool **600** used to leave a minimal amount of outer wall of the stomach **3** on the outside of the plication **3**PL. The portion of the stomach wall **3**W that was not collected into the center of the plication determines the final geometry of the plicated stomach. The more wall that is collected into the center, the less there is on the outer perimeter and the more restricted is the stomach lumen capacity internally. FIG. **18**B illustrates how the rolling action moves an outer wall surface location **604** into the center of the plication, when location **606** is brought into apposition with location **602**.

The method of FIGS. **18**A-**18**C leaves a shorter stomach while also creating a smaller lumen so that the overall pathway for food mimics that of a gastric bypass. FIGS. **18**D-**18**F show anterior view of a greater curvature plication performed using wrapping plication tool **600**. By joining location **608** with **610**, the stomach is effectively shortened, and a smaller lumen **612** is formed in the stomach **3**, so that the effects of a gastric bypass are mimicked. FIG. **18**G illustrate use of wrapping tool **600** to move locations **614**, **616**, **618** to together to join the stomach **3** tissue in two plications **3**PL**1**, **3**PL**2**.

FIG. **19**A illustrates an instrument **700** used in performing a plication of the stomach **3** according to another embodiment of the present invention. In this embodiment, suction ports/holes **712** are spirally positioned along roller body **702** as illustrated in FIG. **19**A. FIG. **19**B is an illustration of the stomach **3** with two lines or "rails" identifying locations of the stomach **3** intended to be joined in a plication **3**PL. Instrument **700** is applied to rail location **3-1** with suction port **712-1** engaging the stomach tissue there. Tube **702** can be rotated to open a specific port, or to attach it to the stomach tissue. By selectively attaching and detaching ports, this separates the management of folding the stomach tissue and connecting the folds of tissue together. Instrument **700** is used to gather up the stomach tissue to be joined and then the plication is manually stitched with conventional suture and needle and laparoscopic tools.

FIG. **20**A illustrates a method in which both of the opposing folds of tissue are passed in opposite directions between rollers **412**, after which they are connected at **3**PL in serosa-to-serosa contact. FIG. **20**B illustrates a method in which a first fold of stomach **3** tissue is secured such as by suturing. Subsequently, the stomach on the opposing side is rolled up further to gather more of the stomach **3** within the plication prior to fixing the opposing side at **3**PL**2**.

In FIGS. **21**A-**21**B a first line of anchors **750** is installed on the surface of the stomach, such as in a location generally following the greater curve **3**G and adjacent thereto, and a second line of anchors **760** is installed adjacent the lesser curve **3**L and generally following the curvature thereof. Then, an attachment member/suture **104** is laced around the anchors **750**, **760** and cinched down as shown in FIG. **21**B. This draws the two sets of anchors **750**, **760** up toward each other, thereby forming a fold/plication in the stomach tissue and reducing the volume of the stomach **3**, as shown in the cross-sectional illustration of FIG. **21**C.

FIG. **22**A illustrates an embodiment in which a mesh sheet **780** is attached to the stomach **3** on a location where a plication is intended to be formed. Sheet **780** includes rails or other connectors **780**A and **780**B (e.g., male/female connectors or the like) on opposite sides thereof. Once sheet **780** is securely fixed to the stomach **3**, the connectors **780**A and **780**B are joined to one another, resulting in the plication **3**PL shown in FIG. **22**B. Mesh **780** is preferably formed of a material that encourages tissue ingrowth, such as any of the materials identified above as tissue ingrowth encouraging materials. This then encourages tissue to grow into the location **782**.

FIG. **23**A is a perspective view of a distal end portion of an instrument **800** that is useful for folding the stomach in the performance of a plication procedure, to position the folded stomach tissues for manual stitching by a surgeon. Instrument **800** can be inserted through a laparoscopic port **802** when in a compact configuration in which folding bars **830** are retracted to the compact configuration beneath the end effector **800**E as shown in FIG. **23**B. FIG. **23**C show a side view of instrument **800** in the compact configuration. Shaft **810** is a fixed shaft that extends proximally of the end effector **800**E and **812** is a rotational shaft that extends proximally form end effector **800**E and is linked to bars **830** so that an operator can rotate the shaft **812** from outside the patient to rotate the bars **830** when they are in the abdominal cavity.

After establishing ports/pathway or other opening leading into the abdominal cavity from outside the patient, the omentum **5** and connective tissues are dissected at the greater curve of the stomach to provide access thereto, the same as described above with regard to FIGS. **7**A-**7**B. A bougie **50**, **50'** may be inserted trans-esophageally and placed in the stomach **3** in a position such as shown and described above with regard to FIG. **7**C, for example.

Once the end effector **800**E and folding bars **830** have been inserted through the laparoscopic port **802** (or through a percutaneous opening for a percutaneous procedure or through a large opening if the procedure is an open surgical procedure) and have entered the abdominal cavity, the instrument **800** is installed on the stomach such that the end effector **800**E is against one external wall of the stomach and the folding bars **830** are in contact with the opposite external wall of the stomach, similar to what is shown in FIG. **11**D with regard to instrument **300"**. Folding bars **830** are elongated along the lengthwise direction of end effector **800**E and preferably extend substantially parallel to the longitudinal axis L-L of end effector **800**E. Folding bars **830** are rotationally mounted to instrument **800**, each bar **830** having a radially extending portion **830**R that is rotationally mounted to the instrument **800** and from which the main longitudinal portion **830**L extends, as shown in FIGS. **23**A and **23**C-**23**E. This arrangement allows the longitudinal portions **830**L of the bars **830** to be rotated relative to end effector **800**E along arcs that are at predetermined distances from the end effector **800**E. Once the instrument **800** end effector **800**E and folding arms **830** are contacted to the stomach **3** and appropriately positioned in the manner described above, the folding bars **830** are rotated in opposite directions relative to one another, upwards to fold the stomach into a "U-shape". The stomach **3** is not shown in FIGS. **23**D-**23**E for clarity, to view the actions and components of the instrument **800**.

Next, at FIG. **23**E, tissue pins/stabilizing pins **302** are deployed from end effector **800**E into the folds of stomach tissue (not shown) to temporarily maintain the stomach folds in the desired positions/orientations for performing the plication. The surgeon may assist in pushing or further pushing the stomach tissue folds down on the pins **302** on both sides. This accurately positions the fold for a very tight, precise plication.

Sutures are then manually placed by the surgeon to attached the two folds of stomach in serosa-to-serosa contact, like illustrated in FIG. **12**F, for example, after which the pins **302** are retracted and the instrument **800** is removed. Optionally instrument **800** can be used along the greater curve **3**G of the stomach to perform a plication after the omentum has been dissected. Optionally an implant may also be placed during the procedure in a manner also similar to that described in regard to FIG. **12**F, as well as in other previous embodiments.

FIGS. **24**A-**24**D illustrate another instrument **900** and use of instrument **900** on the stomach **3** to created folds in the stomach **3** for performing a plication according to another embodiment of the present invention. Instrument **900** includes an elongated, channel-shaped base jaw **902** and a mating jaw **904** that cooperates with base jaw **902**. Base jaw **902** forms an open channel at a distal end **902**D thereof and has sides **902**S that extend upwardly from base **902**B to form the channel. Mating jaw **904** is hinged to base jaw **902** at their proximal end portions as shown in FIGS. **24**A and **24**C. In the end view of FIG. **24**B, it is shown that when the jaws **902**, **904** are in a closed configuration, the mating jaw **904** is mounted such that the lower surface **904**L is parallel to the upper surface **902**U of base **902**B and substantially parallel thereto, to form a gap **900**G therebetween to provide a space for the stomach **3** so as to avoid overly compressing the stomach tissue, thereby avoiding tissue damage, necrosis, etc. Additionally the base **902**B may be provided with an opening **900**H to further relieve stress on the stomach **3** tissue between the jaws in the closed position, as a portion of the stomach **3** tissue therebetween may be forced out through the opening **900**H, thereby reducing the pressure on the tissues.

FIG. **24**C illustrates the instrument **900** in an open position, in which mating jaw **904** is pivoted away from base **902**. Instrument **900** is then installed over the stomach **3** so that base **902** is on one side of the stomach **3** and mating jaw **904** is positioned on the opposite side of the stomach **3**. After such placement, the upper jaw **904** and base **902** are brought back together, to or at least toward the closed position, thereby forcing the stomach tissue **3** to conform into the channel, and shaping the stomach into a substantial "U-shape" as illustrated in FIG. **24**D. At this time, a surgeon can complete the plication by manually suturing the two folds of stomach tissue **3**F**1**, **3**F**2** together, after which the instrument **900** can be at least partially opened to remove it off the stomach, and then closed again to make it as compact a possible for removal from the abdominal cavity and patient. Optionally instrument **900** can be used along the greater curve **3**G of the stomach to perform a plication after the omentum has been dissected.

FIGS. **25**A-**25**B illustrate instrument **1000** and use of instrument **1000** on the stomach **3** to maintain the stomach in the desired folded conformation while sutures are being placed to hold the plication. After establishing ports/pathway or other opening leading into the abdominal cavity from outside the patient, the omentum **5** and connective tissues are dissected at the greater curve of the stomach to provide access thereto, the same as described above with regard to FIGS. **7**A-**7**B. A bougie **50**, **50'** may be inserted trans-esophageally and placed in the stomach **3** in a position such as shown and described above with regard to FIG. **7**C, for example.

Instrument **1000** has a distal end effector **1000**E and a handle **1000**H that extends proximally therefrom. Handle **1000**H has a length sufficient so that a proximal end portion of the handle can be grasped and operated from outside the patient even when the end effector is in its operative position on the target stomach **3** tissue, such as illustrated in FIG. **25**B, for example. The end effector **1000**E is curved about the longitudinal axis L-L of the end effector **1000**E such that the inner walls of the end effector extend lengthwise, substantially parallel to the longitudinal axis L-L. Thus end effector **1000**E forms a partial cylinder, with a gap **1000**G that extends the entire length of the end effector **1000**E so as to permit folded stomach tissue to enter in through the gap **100**G and be held by the walls of the partial cylinder body of the end effector **1000**E during the suturing of the plication. End effector **1000**E may be made of a spring-like material, such as spring steel, Nitinol, or the like. After preparation of the surgical site as described above, the stomach is folded over into the configuration intended to be maintained by the plication, so as to reduce the effective volume of the stomach and thereby effect weight loss. Instrument **1000** is then inserted and end effector **1000**E is slid over the fold of the stomach **3** tissue is then performed while end effector **100**E remains in place to ensure that the stomach **3** remains folded in the manner desired, so as to ensure serosa-to-serosa contact of the stomach tissues being sutured together. As noted above, the end effector **1000**E has a gap **1000**G that is sized to allow the outside wall of the stomach **3** to remain in contact with one another, without being over compressed or damaged. Once the suturing has been completed, the end effector **1000**E is slid off of the folded stomach tissues and instrument **1000** is removed from the patient.

Alternatively instrument **1000** could be formed of wire. Further alternatively, instrument **1000** could be formed of two pieces of curved metal with a hinge and a spring to provided clamping action over the folded stomach **3** tissues.

FIGS. **26**A-**26**D illustrate a method of performing a plication of the stomach according to another embodiment of the present invention. After preparing the surgical site, such as by the techniques described above with regard to FIGS. **7**A-**7**C, for example, the greater curvature portion of the stomach **3**G has been cleared of omentum and vasculature to the extent that it is ready to be folded in a manner desired, see FIG. **26**A. The stomach is then folded, such as by using laparoscopic instruments (graspers or the like) and/or other instruments for a percutaneous or open surgical procedure. Optionally, instrument **1000** may then be used to maintain the stomach in the desired folded configuration with end effector **1000**E. Alternatively, the folded orientation can be maintained using graspers or other instruments.

At FIG. **26**C a needle is used to advance an attachment member/suture **104** through the edges of the fold at the plication line **3**PL to fasten the fold in place. Attachment member **104** has an anchor mate **108** on a distal end portion thereof that interacts with the needle in the same manner as described above with regard to piercing members/suture drivers **102**, as the needle also functions as a piercing member/suture driver **102**. Also, anchor mate **108** mates with anchor **106** at the distal end of the plication line **3**PL as shown in FIG. **26**C. The attachment member/suture **104** is then pulled tight and tied at the proximal end of the stitch **104**P. Optionally, bioglue (e.g., cyanoacrylate glue or other biocompatible adhesive suitable for this purpose) may be applied to the stitch line and plication line (fold seam) for added strength of the attachment.

FIGS. **27**A-**27**B illustrate instrument **1100** and use of instrument **1100** on the stomach **3** to form a plication by rolling according to an embodiment of the present invention. After establishing ports/pathway or other opening leading into the abdominal cavity from outside the patient, the omentum **5** and connective tissues are dissected at the greater curve of the stomach to provide access thereto, the same as described above with regard to FIGS. **7**A-**7**B. A bougie **50**, **50'** may be inserted trans-esophageally and placed in the stomach **3** in a position such as shown and described above with regard to FIG. **7**C, for example.

Instrument **1100** has a distal end effector **1100**E and a handle **1100**H that extends proximally therefrom. Handle **1100**H has a length sufficient so that a proximal end portion of the handle can be grasped and operated from outside the patient even when the end effector **1100**E is in its operative position on the target stomach **3** tissue, such as illustrated in FIG. **27**A, for example.

After preparation as noted above, end effector **1100**E is inserted into the abdominal cavity and contacted to the stomach **3** as illustrate in FIG. **27**A. Tissue pins/stabilizer pins **302** (not shown) are next deployed from the surface of end effector **1100**E that contacts the stomach, so as to better mechanically engaged the stomach tissues. The operator then rotates the handle **27**B (counterclockwise in the embodiment shown in FIG. **27**B). This rotates the end effector **1100**E which is temporarily attached to the stomach tissue via pins **302**, resulting in a rolling up of the stomach into a plication fold as illustrated in FIG. **27**B. The instrument is held in place as shown in FIG. **27**B. The stomach can be held in the rotated configuration by means of a clamp affixed to the shaft extracorporally, while the plication line **3**PL is fixed, such as by suturing. Once the suturing has been securely performed, pins **302** are retracted back into the end effector **1100**E, the end effector **1100**E is rotated is the opposite direction and slid out from within the stomach tissues and instrument **1100** is removed from the abdominal cavity and the patient. Alternative to pins **302**, piercing members or needles such as **102**, **102'**, **102"** could be deployed from end effector **1100**E.

FIGS. **28**A-**28**G illustrate instrument **50"** and use of instrument **50"** within the stomach to function as a bougie and optionally, to make a plication in the stomach **3** by drawing on the stomach tissues from inside the stomach **3**, although the attachment of the folds is preferably still performed by connecting the outside portions of the folds in serosa-to-serosa contact as described in previous embodiments.

Instrument **50"** comprises an elongate flexible tube **1210** having at least two lumens therein. A first lumen **1212** is in fluid communication with suction ports **1218**, and is connectable, at a proximal end portion thereof, to a source of suction so as to apply suction to suction ports **1218**. A second lumen **1214** is in fluid communication with and inflatable anchor **1220** formed at a distal end portion of the instrument **50"**. A proximal end portion of the tubing forming lumen **1214** is connectable to a source of pressure, so as to fill the anchor **1220** with a pressurized fluid to expand it to the configuration shown in FIG. **28**A. By disconnecting lumen **1214** from the source of pressure (or discontinuing the fluid communication with the pressurized fluid source such as by use of a valve and venting the portion of the lumen **1214** leading to the inflatable anchor **1220**, the inflatable anchor can then be deflated to substantially the size of the tubing **1210** for easier installation or removal from the patient. Optionally, a third lumen **1216** may be provided as a main lumen sized and configured to allow instruments such as, but not limited to, an endoscope to be passed therethrough.

As noted above, a tube having known outside diameter can be used as a calibration tube for a plication procedure to adequately size the residual lumen left in the stomach by the plication procedure. Accordingly, instrument **50"** can be used in any of the embodiments described herein that use bougie **50** or **50'**, as an alternative to such use.

In this embodiment, instrument **50"** is useful not only as a bougie, but is operable as a tissue manipulator, utilizing suction through ports **1218** to engage mucosal tissue and draw the entire stomach wall into a fold, as described in more detail below.

At FIG. **28**B instrument **50"** is placed transesophageally, down into the stomach **3**, with the inflatable anchor **1220** placed towards the pylorus **3**P. At FIG. **28**C the anchor **1220** is inflated by delivering pressurized fluid thereto via lumen **1214**. The anchor **1220** expands against the walls of the pylorus **3**P thereby anchoring the distal end of the instrument **50"**.

At FIG. **28**D, the proximal end portion of instrument **50"** extending out of the patient is pushed on to deliver more of the tubing **1210** into the stomach. Because the tubing **1210** if flexible and the instrument is anchored at **1220**, the tubing snakes around and into contact with the mucosa of the greater curvature **3**G of the stomach **3**. Vacuum is applied through suction holes **1218** via lumen **1212** and this attaches the tubing **1210** to mucosa along the greater curvature as illustrated in FIG. **18**D and the cross-sectional view of FIG. **28**E.

At FIG. **28**F, the proximal portion of the tubing **1210** extending outside of the patient is pulled on, to pull some of the tubing **1210** out of the stomach and thus shorten the length of the tubing **1210** that remains inside the stomach. This causes the anchored tube to move toward the lesser curvature **3**L (to the left in FIG. **28**F) thereby pulling a fold **3**F of stomach tissue from the greater curvature **3**G inward, as indicated in phantom in FIG. **28**F and as shown more clearly in the cross-sectional illustration of FIG. **28**G. Thus, this procedure actively sizes the lumen that will remain in the stomach after completion of the procedure, as the fold **3**F is actively pulled by the instrument **50"** into place against the bougie **50"** thereby accurately sizing the lumen all through the stomach **3**. The plication shape is formed and the folds **3**F**1**, **3**F**2** can be fixated, joined by suturing, staples or other attachment features, including, but not limited to automated suturing as described herein, automated stapling, etc.

FIGS. **29**A-**29**D illustrate instrument **50"'** and use of instrument **50"'** within the stomach, according to another embodiment of the present invention, to function as a bougie and optionally, to make a plication in the stomach **3** by drawing on the stomach tissues from inside the stomach **3**, although the attachment of the folds is preferably still performed by connecting the outside portions of the folds in serosa-to-serosa contact as described in previous embodiments.

Instrument **50"'** comprises an elongate flexible tube **1310** and an end effector **1300**E formed in a distal end portion of tube **1310**. FIG. **29**B illustrates a plurality of members **112** interconnected by joints so render the end effector **1300**E flexible. Each member **112** includes at least one suction port **1314** that opens through tubing **1310** for application of suction to the inner stomach wall (mucosa). The suction ports are in fluid communication with a lumen (not shown) in tubing **1310** that is connectable to a source of suction proximal of instrument **5"'** and outside of the patient. FIG. **29**C shows a variation of the end effector of FIG. **29**C, in which members **1312'** are individually separable and snap together. Like the variation in FIG. **29**B, the members **1312'** are formed to fit together to form ball and socket joints therebetween, and each has at least one (multiple in the embodiments shown) suction port **1314** that opens to the outside of the instrument **50"'**. FIG. **29**D illustrates the flexibility provided by the members **1312**, **1312'** in the end effector **1300**E. The portion of the tubing **1310** proximal of end effector **1300**E is flexible but somewhat stiff, similar to the consistency of a garden hose, such that it can be pushed without buckling, but it is still flexible enough to curve to conform to tortuosity of the pathway that it is inserted through, such as curvature of the esophagus, stomach, etc., while still being capable of being advanced by pushing on it from a proximal location outside the mouth of the patient.

Although instrument **50"** is flexible in bending, as illustrated in FIG. **29**D, it is rigid when axially torqued about its longitudinal axis.

In this embodiment, instrument **50'''** is useful not only as a bougie, but is operable as a tissue manipulator, utilizing suction through ports **1314** to engage mucosal tissue and torque the entire stomach wall to roll it into a fold, as described in more detail below.

After connecting instrument **50'''** to a vacuum source, instrument **50'''** is inserted into the patient's esophagus until it enters the stomach **3**. The distal tip **1300**D of instrument **50'''** is blunt and finds its way toward the pylorus **3**P. The end effector **1300**E is flexible, as noted, and so as more of the instrument if fed into the stomach after contacting the tip **1300**D in the pylorus **3**P, the end effector **1300**E curves into contact with the greater curvature of the stomach **3** inside the stomach, much like instrument **50"** does in FIG. **28**D. The vacuum source is turned on and the mucosa of the greater curvature **3**G is thereby attached to the suction ports **1314**. A proximal portion of instrument **50'''** that extends out of the patient is than axially torqued. Since the instrument **50'''** is rigid under axial torqueing, this rotates the end effector **1300**E, thereby rolling up the stomach to a folded configuration suitable for plication. When multiple suction ports **1314** are provide in each member **1312**, **1312'**, this is advantageous as the members attach to multiple locations of the mucosa upon rotating and thereby more securely hold the plication during suturing. The plication line can be sutures via conventional laparoscopic techniques. Once the plication line has been securely sutured, the vacuum can be turned off and instrument **50'''** can be withdrawn from the stomach **3** and the patient. Alternatively, each member **1312**, **1312'** could be provided with a large suction slot rather than a plurality of suction ports. Instrument **50'''** can be used alternatively to the use of **50**, **50'** or **50"** in any of the other embodiments described herein that refer to use of bougie **50** or **50'**. Alternatively, the stiffness of **50**, **50'** or **50'''** can be adjustable by means of a tapered mandrel inserted into an axial lumen. Since the thinner portions of the mandrel are lower in stiffness than the proximal portions, the mandrel can be advance or retracted inside the lumen to adjust the stiffness to the appropriate level for apposition to the greater curvature of the stomach.

FIGS. **30**A-**30**D are plan, end, top and perspective view of an instrument **1400** useable to create a suture line for joining stomach tissues together in a plication. Instrument **1400** includes first and second base members **1400**A and **1400**B each having a contact surface configured to contact stomach **3** tissues to be attached, and to sandwich those tissues therebetween. The contact surfaces each have a plurality of alternating depressions **1400**D and **1400**P that are configured to mate with the depressions **1400**D and protrusions **1400**P of the other base member when the base members are brought together. Accordingly, the sequence of depressions and protrusions of one base **1400**A are offset from that of the other base **1400**B as shown in FIGS. **30**A and **30**B, so that the opposing protrusions **1400**P mate with depressions **1400**D and the opposing depressions **1400**D mate with protrusions. When these bases **1400**A, **1400**B are separated, the stomach tissues to be sutured are placed between the bases at **1402**. When the bases are pressed together, the mating protrusions **1400**P and depressions **1400**D deform the stomach **3** tissues accordingly, forming an undulating shape in the tissues. Once the bases **1400**A, **1400**B are fitted together (FIG. **38**C, **38**D) with the stomach tissues therebetween, a wire **1404** is inserted into a predefined pathway between the bases **1400**A, **1400**B. This wire passes through both layers of stomach tissue **3** that are to be joined, entering and exiting the many undulations of the tissue pair. An attachment member/suture **104** is fixed to the proximal end of the wire **1404**. Once the distal end of the wire **1404** emerges from between the bases **1400**A, **1400**B at the opposite end from which it was inserted, it can be pulled out from between the bases, **1400**A, **1400**B, thereby dragging the suture through the same pathway that the wire had taken thorough the undulations of the tissue layers. The suture **104** can then be secured to the stomach **3** tissue near both proximal and distal ends of the bases **1400**A, **1400**B. Then the bases **1400**A, **1400**B can be separated and removed, leaving the tissues sewn together by suture **104**.

FIG. **31**A is a plan view of an instrument **1500** that can be used to manipulate stomach tissue in furtherance of a plication procedure according to an embodiment of the present invention. Instrument **1500** includes an elongate shaft **1502** and a handle **1504** formed at a proximal end portion thereof. At least one suction hole (preferably a plurality of suction holes **1512**, as shown) is formed in the end effector **1500**E formed at the distal end portion of the shaft **1502**, see FIG. **31**B. A source of suction can be connected to instrument **1500** at port **1506** in handle **1504**. Port **1504** is in fluid communication with holes/ports **1512** via shaft **1502**. The distal end of the shaft is closed. Upon placement of end effector **1500**E in contact with stomach **3** tissue and actuation of vacuum applied to suction holes **1512**, the suction holes, in contact with the stomach **3** tissue, engage the stomach tissue with sufficient force such that movement of the instrument **1500**, such as by an operator moving the handle **1504** from outside the patient to effect movement of the end effector **1500**E, in turn moves the stomach **3** tissue. The suction openings **1512** can be designed so that a collection of instruments **1500** having different sizes and/or numbers of openings **1512** can be provided to allow for the appropriate length of tissue to be grasped. Alternatively, instrument **1500** may be provided with the ability to close off one or more openings. A relatively smaller opening or single opening **1512** could be used to attached to tissue at a single point location, whereas longer or multiple openings **1512** can be used to manipulate longer lengths of tissue **3**. For suturing tissues together, two or more instruments **1500** may be used to manipulate the tissues to be joined to move them into the desired locations for suturing. For plication, different parts of the stomach **3** can be grasped using vacuum, lifted, and then placed close together.

FIGS. **32**A-**32**C illustrates variations of an instrument **1600**, **1600'** that can be used in the performance of a plication procedure on the stomach, according to an embodiment of the present invention. Instrument **1600** is rigid and formed as a T-shaped spine, having a deformation spine **1602** and a cross member **1604**. Instrument **1600** can be made of biocompatible metal or rigid plastic. In use, instrument **1600** is pressed against the stomach so as to trap and plicate the stomach **3** tissue as shown. The deformation spine **1602** causes folding of the stomach tissue and the cross member maintains the outer folds of the plication evenly and up against the deformation spine in preparation for joining them together, such as by suturing or the like. The deformation spine **1602** may be provided with a slot **1602**S (see FIG. **32**C) or other opening or openings that allow suturing therethrough, but still permits the instrument **1600** to be removed after suturing has been performed. In the variation of FIG. **32**C, side guides **1606** extend from the edges of cross member **1604** in substantially the same direction that deformation spine **1602** extends in, thereby better channeling the tissue folds between the deformation spine and the respective side guides **1606**. Once the folds of the stomach have been connected together, instrument **1600** can be slid out and removed from the patient.

Further alternatively deformation spine **1602** may contain a mechanism that automatically holds and/or seals the plicated stomach together.

FIG. **33** illustrates an embodiment that employs an instrument **1600** together with a forked clip **1650**. The empty, relaxed stomach **3** is draped over the instrument **1600** and deformation spine **1602** deforms the stomach **3** tissues, creating the plication. The forked clip **1650** is then applied over the folded stomach **3** tissues to hold them in place against the deformation spine **1602** of instrument **1600**. Instrument **1600** is then removed, sliding the deformation spine **1602** out from between the folded tissues and leaving the folds of the stomach clipped together by instrument **1650**, thereby reducing the volume of the stomach. Additionally the clamped, folded tissues can be sutured, stapled or otherwise further connected, and instrument **1650** can be left in place or removed.

FIG. **34** illustrates a dumbbell-shaped implant **10** that can be implanted in a plication according to procedures described herein. Implant **10** includes an elongate, substantially cylindrical, central body portion **10**B having a first cross-sectional dimension (diameter) with enlarged portions **10**E formed at both ends of the central body portion **10**B. Then enlarged portions are bulbous and have a cross-sectional dimension larger than the cross-sectional dimension of the central body. In the embodiment shown, each enlarged portion is substantially spherical and has a cross-sectional dimension (diameter) **10**C**2** that is greater than the cross-sectional diameter **10**C**1** of the central body **10**B.

A plicated stomach can expand over time. By attaching an inflatable implant **10** in the folded stomach **3** as illustrated in FIG. **34**, this allows adjustment of the compression on the stomach, and thus compensation for expansion of the stomach, by expanding the implant **10** further, without the need for further surgery. The main body (narrow section) of the implant **10** is attached inside the plicated stomach, while the enlarged portions **10**E extend out towards the fundus end of the stomach **3** as well as the antrum. The implant is inflatable via a subcutaneous port **80** in fluid communication with an inflation tube **12** which we have already described in detail previously. By making the implant **10** dumbbell-shaped, the size can be made universal. In patients with a relatively shorter length of the plicated stomach **3**, the enlarged ends **10**E of the dumbbell-shaped implant **10** will occupy space and prevent the motion of the implant **10** out of its intended location. In plicated stomachs **3** that are relatively long, the dumbbell-shaped implant **10** will still function by providing adequate restriction while one or both of the enlarged portions are inflated inside of the plicated area. The dumbbell shape of the implant **10** can reduce the number of attachments required since additional anchoring is provided by the enlarged ends **10**E. This can result in smaller instruments being used to perform the attachment procedures and enable linearity of the attachment locations, thus overcoming challenges in stitching along the curvature of the stomach. Alternative shapes for implant **10** include, but are not limited to: substantially cylindrical (already described above), disc-shaped or cube-shaped.

FIGS. **35**A-**35**C are perspective views of an attachment instrument **400'''** according to another embodiment of the present invention, configured to be operated from outside of a patient, with the end effector having been inserted through a laparoscopic port or percutaneous opening and into contact with the patient's stomach **3** (e.g., into the abdominal cavity of the patient), and to reduce the effective volume of the stomach **3** by performing one or more plication procedures on it. Of course instrument **400'''** could also be used during open surgery.

Attachment instrument **400'''** includes an elongate end effector **400**E''' comprising first and second end effector portions **400**E**1'''** and **400**E**2'''** and operates similarly to attachment instrument **400** with notable differences described hereafter. A joint **423** is provided intermediate of shaft **420'''** that permits the operator, after inserting the end effector **400**E''' into the abdominal cavity to operate the handle **430'''** from outside of the patient to articulate the end effector **400'''** and distal end portion **420**D of shaft **420'''** relative to the proximal end portion **420**P of shaft **420'''** and handle **430'''**. This can assist in orienting the end effector **400**E''' more tangentially to the stomach **3** before contacting it, than what otherwise might be possible in embodiments where the end effector has to remain aligned with the entire shaft and handle, the angle of which is sometimes not optimum in view of the angle of approach needed to be taken when inserting the instrument from outside the patient and into the abdominal cavity. An example of this is illustrated in FIG. **3**I.

FIG. **35**A illustrates instrument **400'''** in a configuration where lower contact plate **402'''** on end effector portion **400**E**2'''** is spaced beneath and parallel with an upper tissue contact surface **404'''** on the end effector portion **400**E**1'''** of the end effector **400**E''', forming a gap **400**G between plate **402'''** and surface **404'''** as shown. Actuators **432**D and **432**P are cyclically actuatable to operate distal ratchet driving mechanism **434**D and proximal ratchet driving mechanism **434**P respectively, to vary the distances between the plate **402'''** and surface **404'''** at **434**D and **434**P and locations therebetween. The independently operable ratchet systems **434**D, **434**P are independently controllable to better account for varied thicknesses of the stomach **3** along the plication line.

Optionally the end effector **400**E''' may be slightly curved relative to its longitudinal axis, as shown, to better match the curvature of the bougie **50**, **50'**, **50"**, **50""** and/or lesser curvature **3**L of the stomach **3**, so as to achieve a plication line **3**PL that better conforms to the lesser curvature **3**L resulting in a more consistent cross-sectional size and shape of the lumen that is left in the reduced stomach, see FIGS. **35**D and **35**E. Alternatively, the end effectors **400**E''' could be designed to have linkages along their length to allow the user to adjust the overall curvature to match the curvature of the bougie **50**, **50'**, **50"**, **50'''** and inner curvature of the stomach **3** (i.e., lesser curvature **3**L).

Actuator/button **436** when pressed/actuated, activates a suction system supplied with suction via suction line **116** and which functions like previously described suction ports used to help ensure that tissue to be plicated is properly positioned. Actuator/button **438** has an appearance like actuator/button **436** but is positioned on the opposite side of handle **430'''**. When pressed/actuated, actuator/button **438** activates the tissue clamping system of instrument **430'''**, which actuates small clamping features along the end effectors **400**E''' that clamp onto the stomach tissue at locations near the locations where the tissue contacts the suction features. This tissue clamping thereby complements the engagement of the tissue by the suction system. Upon properly positioning the stomach tissue **3** between the surfaces **404'''** and **402'''**, the drivers **434**P, **434**D are driven as necessary to contact the tissues all along the plication line and adjust the gap **400**G so that the surfaces will apply pressure evenly along the plication line during clamping. Upon actuating the clamping system using actuator **438**, the contact surfaces **402'''**, **404'''** clamp the tissues to be attached, as illustrated in FIG. **35**B. Further adjustment of the ratchet drivers **434**P, **434**D may be performed at this time to achieve a more even distribution of clamping force, if needed. FIG. **35**C illustrates the ability of

the drivers **434**P, **434**D to completely close the end effector **400**E''' so that there is no gap **400**G between **402**''' and **404**'''. FIG. **35**F is an enlarged, detail view of the portion of FIG. **35**A outlined by box **35**F. FIG. **35**F better shows the suture anchors **106** and suction ports **112** in end effector **400**E**2**''' that are open to surface **402**'''.

FIG. **36**A is a side view of an attachment instrument **600** according to another embodiment of the present invention. Instrument **600** is configured to engage stomach tissue via suction (and optionally, additional mechanical clamping force as described after this embodiment) like instruments **100**, **200**, **400**, **400'**, **400''**, **400'''**, etc., but unlike instrument **100**, **400**, **400'**, **400''** and **400'''**, instrument **600** is not configured to perform suturing/fixation of the serosal tissues together (other than temporarily by clamping action until something more permanent is installed). In this embodiment, instrument **600** is used to engage the stomach tissues by suction or by suction and mechanical clamping.

Instrument **600** can be inserted into the abdominal cavity and a working end thereof is positioned over a location on the stomach **3** where a plication line **3**PL is intended to be formed. The working end is the distal end portion of the instrument **600** and includes a first end effector **600**E**1** and a second end effector **600**E**2** extending alongside and opposing first end effector **600**E**1**. These end effector **600**E (**600**E**1**, **600**E**2**) can be straight, or can be slightly curved relative to its longitudinal axis, as shown in FIG. **36**A, to better match the curvature of the bougie **50**, **50'**, **50''**, **50''''** and/or lesser curvature **3**L of the stomach **3**, so as to achieve a plication line **3**PL that better conforms to the lesser curvature **3**L resulting in a more consistent cross-sectional size and shape of the lumen that is left in the reduced stomach. Alternatively, the end effectors **600**E could be designed to have linkages along their length to allow the user to adjust the overall curvature to match the curvature of the bougie **50**, **50'**, **50''**, **50'''** and inner curvature of the stomach **3** (i.e., lesser curvature **3**L).

One of end effectors **600**E**1**, **600**E**2** can be placed on a posterior surface of the stomach **3** and the other can be placed on an anterior surface of the stomach **3** along a line opposed to a line of the posterior surface that the first end effector contacts, like that described above with regard to instrument **200** in FIG. **5**D. The end effectors **600**E**1**, **600**E**2** engage the surfaces of the stomach **3** that they are contacted to by application of negative pressure through suction ports **112** (see FIG. **36**B) defined in the contact surfaces **602**, **604** of the end effectors **600**E**2**, **600**E**1** (and optionally, additional mechanical clamping force as described in more detail below), respectively. The engagement forces are sufficiently strong so that when the end effectors **600**E**1**, **600**E**2** are separated (moved away from one another) as the portions of the stomach wall engaged by the end effectors are also drawn apart, thereby expanding the interior volume within the stomach **3** (like shown in FIG. **5**E when using instrument **200**).

Next, a portion of the stomach forming at least a portion of the greater curvature **3**G is plicated (i.e., tucked) into the gap **600**G formed by separating the end effectors **600**E**1**, **600**E**2** (like shown in FIG. **5**F when using instrument **200**). The plicated portion of the stomach **3** is folded to an extent that it is located on the opposite side of the intended plication line, relative to its pre-plicated location, as can be observed by comparing FIG. **5**E with FIG. **5**F. Optionally, but preferably, prior to plicating the portion of the stomach **3**, the operator of the instrument **600** may rotate the instrument **600** by about ninety degrees (counterclockwise in the embodiment shown in optional step of FIG. **5**F') about its longitudinal axis. This option positions the stomach **3** to allow gravity to assist in plicating the portion **3**G through the gap **600**G, making the plicating much easier as the portion **3**G "falls" in through gap **600**G.

Once the portion **3**G has been folded appropriately according to either optional technique described above, the instrument **600** is then operated to move the end effectors **600**E**1**, **600**E**2** together again thereby closing the plication (like shown in FIG. **5**G when using instrument **200**). At this time, a surgeon sutures the plication so as to more permanently attached the stomach tissues together in serosal to serosal contact so as to maintain the configuration shown in FIG. **5**G. Thus, rather than using an instrument to perform the suturing via an automated instrument like in FIGS. **5**G-**5**L, instrument **600** is configured for manual suturing of the plication. The surgeon will typically manually sew, via needle **602** and suture **104** (FIG. **36**C) a set of interrupted sutures **604** along the plication line, followed by a second suture line **606** (see FIGS. **36**D-**36**E), which may be a continuous running stitch or a second set of interrupted sutures. Further alternatively, only one row of sutures **604**, typically a set of interrupted sutures, may be employed, as illustrated in FIGS. **36**F-**36**G.

As a further option, an expandable implant **10** may be implanted (manually sutured in place by a surgeon, like descried above with regard to FIG. **5**L except using instrument **600** and replacing instrument **150** by manual suturing) to fill the inside of the plication **3**PL. The implant **10** may be a silicone bladder, for example, capable of being inflated by biocompatible fluid such as liquid, gas, or a combination of fluids (gases, liquids, or liquids and gases). Implant **10** is connected via fill tubing **12** in fluid communication with a subcutaneous fill port **80**, so that the fill volume of implant **10** can be adjusted after implanting it as described from a location outside of the abdominal cavity (e.g., by an operator accessing the subcutaneous fill port **80** with a needle alone or a needle attached to a pressurized source of fluid). Other implants **10** may be substituted, but need to be expandable and are preferably controllable as to amount of expansion. A tab or wing **11**, **11'**, **11''**, **11'''** may be provided to extend from the expandable body of the implant **10** and can be inserted between the tissue folds at the plication suture line so that the attachment members/sutures **104** are also installed through the tab or wing **11**, **11'**, **11''**, **11'''** to thereby securely hold the implant in place, as illustrated in FIG. **5**L. The tab or wing **11**, **11'**, **11''**, **11'''** may be made of a mesh-reinforced silicone, for example. Alternatively, the implant **10** may be fixed in place by connecting only to the superior and inferior ends of the plication suture line, or by connecting to one or more of the interrupted sutures.

Instrument **600** includes an elongate end effector **600**E comprising first and second end effector portions **600**E**1** and **600**E**2** and operates similarly to attachment instrument **400'''** with regard to tissue attachment, separation and clamping functions. As already noted however, instrument **600**, unlike instrument **400'''** does not perform suturing of the plication. A joint **623** is provided intermediate of shaft **620** that permits the operator, after inserting the end effector **600**E into the abdominal cavity to operate the handle **630** from outside of the patient to articulate the end effector **600**E and distal end portion **620**D of shaft **620** relative to the proximal end portion **620**P of shaft **620** and handle **630**. This can assist in orienting the end effector **600**E more tangentially to the stomach **3** before contacting it, than what otherwise might be possible in embodiments where the end effector has to remain aligned with the entire shaft and handle, the angle of which is sometimes not optimum in view of the angle of approach needed to be taken when inserting the instrument from outside the patient and into the abdominal cavity.

In certain embodiments, joint **623** is controlled at handle **630** through a rod linked to a threaded traveller riding on a threaded screw. Turning the threaded traveler such that it rides distally along the long axis of the device in turn pushes the rod. The rod extends joint **623** such that distal end portion **620**D forms a more obtuse angle with respect to proximal end portion **620**P. Conversely, turning the threaded traveler such that it rides proximally along the long axis of the device retracts joint **623** such that distal end portion **620**D forms a more acute angle with respect to proximal end portion **620**P. It is understood that other mechanical systems for extending and retracting joint **623** are contemplated as within the scope of the invention.

FIG. **36**A illustrates instrument **600** in a configuration where lower contact plate **602** on end effector portion **600**E**2** is spaced beneath and parallel with an upper tissue contact surface **604** on the end effector portion **600**E**1** of the end effector **600**E, forming a gap **600**G between plate **602** and surface **604** as shown. Actuators **632**D and **632**P are cyclically actuatable to operate distal ratchet driving mechanism **634**D and proximal ratchet driving mechanism **634**P respectively, to vary the distances between the plate **602** and surface **604** at **634**D and **634**P and locations therebetween. The independently operable ratchet systems **634**D, **634**P are independently controllable to better account for varied thicknesses of the stomach **3** along the plication line.

Actuator/button **636** when pressed/actuated, activates a suction system supplied with suction via suction line **116** and which functions like previously described suction ports used to help ensure that tissue to be plicated is properly positioned. Actuator/button **638** has an appearance like actuator/button **636** but is positioned on the opposite side of handle **630**. When pressed/actuated, actuator/button **638** activates the tissue clamping system of instrument **630**, which actuates small clamping features along the end effectors **600**E that clamp onto the stomach tissue at locations near the locations where the tissue contacts the suction features. This tissue clamping feature is described in greater detail below. This tissue clamping thereby complements the engagement of the tissue by the suction system. Upon properly positioning the stomach tissue **3** between the surfaces **604** and **602**, the drivers **634**P, **634**D are driven as necessary to contact the tissues all along the plication line and adjust the gap **600**G so that the surfaces will apply pressure evenly along the plication line during clamping. Upon actuating the clamping system using actuator **638**, the contact surfaces **602**, **604** clamp the tissues to be attached, similarly to what is shown in FIG. **35**B with regard to instrument **400'''**. Further adjustment of the ratchet drivers **634**P, **634**D may be performed at this time to achieve a more even distribution of clamping force, if needed. The drivers can be configured with the ability to completely close the end effector **600**E, if desired, so that there is no gap **600**G between **602** and **604**. FIG. **36**B is an enlarged, detail view of the portion of FIG. **36**A outlined by box **36**B. FIG. **36**B better shows the suction ports **112** in end effector **600**E**2'''** that are open to surface **602**. Additionally, FIG. **36**B better shows the recesses or scallops **610** formed in the end effectors **600**E**1** and **600**E**2** all the way through the thicknesses thereof, including the contact surfaces **604** and **602**. The recesses/scallops **610** in end effector **600**E**1** are aligned with the recesses/scallops **610** in end effector **600**E**2** and are configured and dimensioned to facilitate manually installing/sewing sutures **104** therethrough by the surgeon. By installing interrupted sutures through a plurality of the recesses/scallops **610** (typically all recesses/scallops that sandwich stomach tissue are sutured, although fewer could be sutured) this fixes the plication line **3**PL independently of the instrument **600**, so that the stomach tissue are held in serosa-to-serosa approximation after completion of the suturing, and unclamping and removal of the instrument **100**. The interrupted sutures do not constrain the end effectors **600**E**1**, **600**E**2** in any way, so that the end effectors **600**E**1**, **600**E**2** can be maintained clamping the tissues until at least the first line of interrupted sutures have been completed. Removal of the end effectors and instrument **600** can be readily accomplished without affecting tensioning of the sutures or the condition of the plication line.

FIGS. **37**A-**37**C are schematic representations illustrating functioning of a tissue engagement arrangement for engaging stomach tissue during procedures discussed above. Alternative to the use of suction only, this approach uses secondary mechanical clamping, in addition to suction to engage the stomach tissues. In the schematics shown, the surface of the page represents contact surface **404'''**. The distal end of the instrument is to the left in the schematics and the proximal direction is to the right. With the secondary mechanical clamping non-actuated as shown in FIG. **37**A, stomach tissue is pulled into the slots **112** by application of suction through the slots **112**. Secondary clamp actuator **138**, which is operable by the user of the instrument from outside of the patient, for example, by actuating actuator/button **438**, is in its non-actuated position as shown in FIG. **37**A.

By drawing the actuator **138** proximally relative to the remainder of the instrument, actuator lobes **138**L of actuator **138** drive clamping wires **139** against the stomach tissues engaged by the slots **112** and wedge the tissues against the inside surface of the slots **112**. To release the secondary clamping, the operator can pull the actuator **138** further proximally so that the lobes **138**L are positioned in between the slots **112** as illustrated in FIG. **37**C, allowing clamping wires **139** to resiliently return to positions away from the tissues so that they no longer clamp the tissues. Alternatively, the operator can push the actuator **138** back distally, allowing the camping wires to resiliently return to positions away from the tissues so that they no longer clamp the tissue in the slots **112**.

FIGS. **38**A-**38**H provide various partial views of an instrument **100'** that employs suction as a primary clamping feature and a mechanical secondary clamping feature according to an embodiment of the present invention. It is noted here that although the instrument **100'** is similar to the construction and function of instrument **100** shown in FIG. **3**A, that the secondary mechanical clamping features shown and described in this embodiment are not limited to instruments **100** and **100'**, but can be employed in any of the instruments described herein that use suction to engage the stomach tissue, as additional securement of the stomach. These features are also not limited to those instruments that both engage the stomach tissue and attach the tissues in serosa-to-serosa contact, as they can also be employed in instrument that engage by suction, but do not perform suturing (such as instruments **200** and **600**, for example). It is further noted that although the embodiment **100'** in FIG. **38**A provides a series of individual actuators **122'** for individually driving piercing members/suture drivers **102** into suture anchors **106**, that typically instruments described herein use a sled pulled along by a cable to automatically press the piercing members/suture drivers **102** through the stomach tissues and into the suture anchors **106**, as described above. The piercing members/suture drivers **102** can be pressed/driven into the tissues all at once simultaneously, in any of the manners described previously and below. Alternatively, the piercing members/suture drivers **102** may be driven individually, as noted above. FIGS. **41**A-**41**E are various partial views illustrating an alternative driving arrangement for an attachment instrument, which is alternatively available for instrument **100'** but can also be

readily adapted for use in other attachment instruments described herein. An actuation mechanism **1020** is provided for individually driving piercing members/suture drivers **102** into suture anchors **106**. Actuation mechanism **1020** includes a sled **1022** that pulled along by a cable (or, alternatively, pulled or pushed by a screw drive mechanism or other driving mechanism) to press the piercing members/suture drivers **102** through the stomach tissues and into the suture anchors **106**, as described above. A driver head **1024** is mounted on top of each piercing member/suture driver **102** as shown. As illustrated in the enlarged partial view of FIG. **41**B, a leading ramp or cam **1026** mounted on a proximal end portion (but could be on the distal end portion for embodiments wherein the sled is pushed rather than pulled) of sled **1022** and is provided with a cam surface **1028** configured to cooperate with cam surface **1030** of driver head **1024** to drive the piercing member/suture driver **102** further out of the instrument as shown by the second to the leftmost piercing member/suture driver **102** in FIG. **41**A. As the sled **1022** advances further and the leading ramp **1030** clears the drive head **1024** that it has just depressed, a trailing ramp or cam surface **1032** of a trailing ramp **1034** that is mounted on a distal end portion (but could be on the proximal end portion for embodiments wherein the sled is pushed rather than pulled) of sled **1022** cooperates with cam surface **1036** of driver head **1024** to drive the piercing member/suture driver **102** in the opposite direction, further into the instrument, back to its undeployed, starting position as shown by the leftmost piercing member/suture driver **102** in FIG. **41**A. At the same time, the leading ramp **1030** engages the next driver head to deploy the next piercing member/suture driver **102**. This process continues to sequentially and individually deploy each piercing member/suture driver **102** until all of them have been deployed. Flexure arms **1038** with stops **1040** are provided both proximally and distally of each piercing member/suture driver **102** to guide the placement and travel of each piercing member/suture driver **102** and to provide an end stop to the return travel as the piercing member/suture driver **102** returns to its undeployed position. A pull cable **1042** is illustrated in FIG. **41**B to pull the sled **1022** proximally relative to the end effector. Alternatively, a pulley could be employed so that when the cable **1042** is pulled proximally, it would pull the sled **1022** distally. As noted earlier, alternative drivers, including, but not limited to a screw drive, could be employed to pull or push the sled **1022**. A rail **1044** is provided to guide the travel of the sled in a lengthwise direction along the end effector and to help maintain alignment of the ramps **1030** and **1034** with the driver heads **1024**. The sled **1022** is further secured and guided by the roof and side wall of the end effector, which are not shown in FIGS. **41**A-**41**B.

FIG. **41**C is a schematic front view (looking toward the distal end of the end effector) showing the piercing member/suture driver **102** being driven out of the end effector to its furthest extent by the driving action of the leading ramp **130** against the driver head **1024**. FIG. **41**D is a schematic rear view (looking toward the proximal end of the end effector) showing the piercing member/suture driver **102** being retracted fully to the undeployed position in the end effector by the driving action of the trailing ramp **134** against the driver head **1024**. FIG. **1022** illustrates a top view of the distal end portion of FIG. **41**A.

FIG. **42**A illustrates an alternative embodiment of an individual driver mechanism in which the sled **1022'** rides over the top of the drive head **1024'** and FIG. **42**B illustrates the compact construction of this embodiment as the sled **1022'** travels between the tissue clamps **106**.

FIGS. **43**A-**43**C illustrate arrangements and methods for installing a running stitch using an attachment instrument according to various embodiments of the present invention. A running stitch may be preferable to the interrupted stitches described thus far in regard to the attachment instruments above, in at least some situations, such as to provide a second line of suturing (additional to a primary line of suturing that may be interrupted sutures or a running stitch) to prevent herniation of a gastric plication. As described above, the instruments create single stitches, which can be utilized as interrupted stitches. Each anchor mate **108** is molded or otherwise fixed to a suture, and each anchor mate **108** is placed through the tissue desired to be stitched, into the anchor **106** on the other side of the tissue to create the stitch. A suture lock may be utilized to tighten and lock the suture in place. Each individual or interrupted suture is created in this fashion.

In the embodiments of FIGS. **43**A-**43**C, to create a running stitch, the first anchor mate **108** (leftmost anchor mate **108** in FIG. **43**A, rightmost anchor mate **108** in FIGS. **43**B-**43**C) on the distal end of the suture **104** is also permanently fixed to the suture **104**. The suture **104** then is loaded with multiple anchor mates **108** bullets that are free to move along the length of the suture **104** similar to beads on a string. The first anchor mate **108** is placed through the tissue desired to be stitched into an anchor **108**. This creates one anchoring point of the suture **104**. Each subsequent anchor mate **108** is fired through the tissue into each subsequent anchor **106**, respectively. This can be accomplished singularly at the discretion of the physician, or can be preloaded in multiple sequence so that all the intended anchor mates **108** are fired in a predetermined configuration (i.e. predetermined number of anchor mates **108**, spacing between anchor mates **108**, using straight suture drivers **102** or curved suture drivers **102**, etc.). Since the distal end of the suture **104** is anchored by the fixed anchor mate **108**/anchor **106** connection and each subsequent anchor mate **108** allows the suture **104** to move freely, once all connections are made, the suture **104** can be pulled from the proximal end to tighten through a suture lock mechanism. The suture lock can additionally or alternatively be incorporated into one or more sliding anchor mates **108** by creating locking teeth within the sliding ring **108**S of the anchor mate **108**. The physician can control the tension on the suture **104** as desired. FIG. **43**B illustrate an arrangement where all anchor mates **108** are driven through the tissues from the same side of the tissues being joined. To create a more spiral shaped running suture the pattern of the anchor mates **108**/anchors **106** can be alternated from one side of the tissue to the other, as illustrated in FIG. **43**C.

Referring back again to the embodiment of FIGS. **38**A-**38**H, the suction ports **112** are annular, surrounding the suture anchors **106** and located between the suture anchors **106** and tissue contacting surface **1104** of end effector **100**E**2'**, as shown in the detailed view of FIG. **38**B. As illustrated in FIG. **38**E, a clamp actuator feature **138**A is provided for each end effector (upper and lower) that is slidable by the operator of instrument **100'** to effect mechanical clamping and unclamping as described in more detail below.

FIG. **38**C illustrates the positions/orientations of clamping jaws **138**J relative to the suture anchors **106**, wherein a gap is maintained therebetween in which the suction ports **112** are located. It should be noted here, that although the clamping mechanism is descried here with particularity with regard to the lower end effector, that the upper end effector contains the same mechanism, except a stationary is provided to surround each suture driver **102**, through which suture driver **102** is slidable, and the stationary feature has tissue clamped against it in the same way the tissue is clamped against the anchor **106**

in the lower actuator. The clamp actuator **138** that is drivable by actuator feature **138**A is in an unclamped position in FIG. **38**C. The cross-sectional view in FIG. **38**D taken along line **38**D-**38**D of FIG. **38**C better illustrates the gap between unclamped jaw **138**J and suture anchor **106** that permits air flow and stomach tissue (drawn by suction applied via vacuum chambers **112**V).

With the secondary mechanical clamping non-actuated as shown in FIGS. **38**A-**38**D, stomach tissue is pulled into the gaps between the jaws **138**J and suture anchors **106** by application of suction through the suction ports **112**. Upon advancing (sliding) the actuator feature **138**A as illustrated in FIG. **38**E, this drives the actuator **138** distally relative to the end effector and drives the actuator lobes **138**L into contact against clamping jaws **138**J. This drives the clamping jaws **138**J towards the suture anchor **106**, thereby mechanically clamping stomach tissues that were drawn into the gaps, between jaws **138**J and suture anchor **106**, see FIG. **38**F. FIG. **38**G is a top view of FIG. **38**F which more clearly shows the clamping jaws **138**J in the clamping position relative to the suture anchor **106**, such that tissues between these features would be securely mechanically clamped.

FIG. **38**H is a cross-sectional view of FIG. **38**G taken along line **38**H-**38**H that better shows the contact between the actuator lobes **138**L and clamping jaws **138**J, as well as showing the jaws **138**J having been driven toward (and in this case in contact with, although that is not always absolutely necessary) suture anchor **106** in the clamping configuration.

This tissue clamping complements the engagement and grasping of the stomach **3** tissue by the suction system, and provides a stronger grip on the stomach **3** tissue so that the instrument does not prematurely release its grip on the stomach **3** tissue. To release the secondary clamping, the operator can pull the actuator **138** proximally so that the lobes **138**L no longer contact the clamping jaws **138**J, like shown in FIG. **38**A, whereupon the clamping jaws **138**J resiliently return to their unclamped positions shown in FIG. **38**C, thereby allowing tissue to be released upon deactivation of the suction.

FIGS. **39**A-**39** illustrate various events for the performance of a procedure for decreasing the effective volume of a patient's stomach that includes extragastric procedures on the stomach to create at least one plication, according to another embodiment of the present invention. After establishing ports/pathway into the abdominal cavity from outside the patient, the omentum **5** and connective tissues are dissected at the greater curve of the stomach to provide access thereto, the same as described above with regard to FIGS. **7**A-**7**B. A bougie **50**, **50'**, **50"**, **50"'** is inserted trans-esophageally and placed in the stomach **3** in a position like shown in FIG. **7**C and the cross-sectional schematic representations in FIGS. **39**A-**39**K. Typically the bougie **50**, **50' 50"**, **50"'** occupies a pathway extending naturally from the esophagus, through the stomach **3** and into the pylorus **3**P, so as to occupy a space similar to what is defined when a sleeve gastrectomy is performed. The bougie acts as a guide so as to better standardize the sizes and locations of plications formed by the procedure as well as to prevent reducing the stomach **3** too aggressively, so as to ensure no blockage locations are inadvertently formed.

In the embodiments of FIGS. **39**A-**39**K the functions of the instruments performing the procedure are divided among at least two instruments. Engagement and manipulation of the stomach tissue are performed using and engagement instrument **1200** or two or more laparoscopic grasper instruments **1202**, **1204** as described below. Engagement instrument **1200** is configured like instrument **200** or could be configured like instrument **200'**, but in each case, engagement is performed by graspers jaws **1206** or other clamping mechanism that are included in instrument **1200** instead of the suction ports of instrument **200**, **200'**. In the same manner the instrument **200**, **200'** or any other instrument described herein may employ suction ports in only one end effector, while providing the contact surface of the opposite end effector with enhanced friction capability (e.g., by knurling, or providing some other surface treatment and/or coating to increase friction), instrument **1200** may optionally be provided with grasper jaws **1206** on only one of end effectors **1200**E**1** or **1200**E**2**, while providing the other end effector with a contact surface exhibiting enhanced friction, but without grasper jaws. In this optional case, as well as with engaging with a suction instrument having suction on only one end effector, the procedures described can still be carried out effectively, except for the optional rotation step like that shown in FIGS. **2**F', **5**F' and **39**E'. Other features of instrument **1200**, such as shaft, handle and optional shaft joint can be the same as or similar to those of instruments **200**, **200'** and others of those described above. Stitching instrument **1250** is configured like instrument **250** (or can be configured like **250'** when **1200** is configured like **200'**) with the piercing members/suture drivers **102**, attachment members/sutures **104**, anchors **106**, anchor mates **108**, suture locks **110** and actuation mechanisms therefore, but without suction ports **112** (although, optionally, suction ports may be included in the end effectors of instrument **1250**) or connection/joint mechanism. Also included are shaft **120**, handle **114** and, optionally, suction line **116**.

Engagement instrument **1200** is inserted into the abdominal cavity and a working end thereof is positioned over locations on the stomach **3** where a plication line is intended to be formed. The working end is the distal end portion of the instrument **1200** and includes a first end effector **1200**E**1** and a second end effector **1200**E**2** (cross-sectional illustrations of end effectors **1200**E**1** and **1200**E**2** are schematically represented in FIGS. **39**C-**39**H) extending alongside and opposing first end effector **200**E**1**. One of the end effectors **1200**E**1**, **1200**E**2** is placed on a posterior surface of the stomach **3** and the other is placed on an anterior surface of the stomach **3** along a line opposed to a line of the posterior surface that the first end effector contacts. In the embodiment shown in FIG. **39**C, end effector **1200**E**1** is contacted to the anterior surface, and end effector **1200**E**2** is contacted to the posterior surface. Alternatively, end effector **1200**E**1** could be contacted to the posterior surface, and end effector **1200**E**2** could be contacted to the anterior surface.

The operator of instrument **1200** then actuates end effectors **1200**E**1**, **1200**E**2** to engage the surfaces of the stomach **3** that they are contacted to with grasping jaws **1206** as illustrated in FIG. **39**C. Alternative to use of instrument **1200**, grasper instruments can be used to carry out the functions of instrument **1200**. In this case, the working end (end effector) **1202** of a first grasper is inserted into the abdominal cavity and positioned over locations on the stomach **3** where a plication line is intended to be formed, see FIG. **39**A. The operator then actuates the grasper to engage the surfaces of the stomach **3** that the grasping jaws of grasper distal end **1202** as illustrated in FIG. **39**B. Optionally, but preferably, the graspers include a locking feature that allows the user to lock the grasper jaws in the configuration shown in FIG. **39**B. Alternatively, the grasping of the tissue may be performed with a different type of mechanism, such as providing **1206** as rollers that rotate to pinch and grasp the tissue, or multiple small rotating needles that pierce into the tissue to grasp the tissue wall. The steps of FIGS. **39**A-**39**B are repeated with a second graspers instrument so that a location on the stomach opposite the location where graspers (end effector) **1202**

grasps the stomach is grasped by the working end/end effector **1204**/grasper jaws **1206** of the second grasper instrument as illustrated in FIG. **39**C. From FIG. **39**C forward, the procedures conducted as described with reference to FIGS. **39**C through **39**H can be carried out using instrument **1200** or, alternatively, two or more grasper instruments **1202**, **1204**.

The working end of instrument **1200** is the distal end portion of the instrument **1200** and includes a first end effector **1200**E**1** and a second end effector **1200**E**2** (cross-sectional illustrations of end effectors **1200**E**1** and **1200**E**2** are schematically represented in FIGS. **39**C-**39**H) extending alongside and opposing first end effector **200**E**1**. One of the end effectors **1200**E**1**, **1200**E**2** is placed on a posterior surface of the stomach **3** and the other is placed on an anterior surface of the stomach **3** along a line opposed to a line of the posterior surface that the first end effector contacts. In the embodiment shown in FIG. **39**C, end effector **1200**E**1** is contacted to the anterior surface, and end effector **1200**E**2** is contacted to the posterior surface. Alternatively, end effector **1200**E**1** could be contacted to the posterior surface, and end effector **1200**E**2** could be contacted to the anterior surface. Whether using instrument **1200** or graspers **1202**, **1204**, the engagement forces are sufficiently strong so that when the end effectors **1200**E**1**, **1200**E**2** (or **1202**, **1204**) are separated (moved away from one another) as illustrated in FIG. **39**D, the portions of the stomach wall engaged by the end effectors are also drawn apart, thereby expanding the interior volume within the stomach **3**. It is noted here that separation of the end effectors **1200**E**1**, **1200**E**2** or graspers **1202**, **1204** to expand the interior volume within the stomach does not require that both end effectors **1200**E**1** and **1200**E**2** be moved, or that both graspers **1202** and **1204** be moved. Rather, only relative movement between the two is required. Therefore, alternatively, end effector **1200**E**1** can be moved while holding end effector **1200**E**2** stationary or end effector **1200**E**2** can be moved while holding end effector **1200**E**1** stationary. Likewise graspers instrument **1202** can be moved while holding graspers instrument **1204** stationary or graspers instrument **1204** can be moved while holding graspers instrument **1202** stationary. Likewise, all other procedures described herein to separate the stomach walls apart so as to increase the interior volume of the stomach can be performed by moving both of the engaged members apart, or moving only one or the other of the engaged members away from the other while holding the other stationary.

Next, a portion of the stomach forming at least a portion of the greater curvature **3**G is plicated, i.e., tucked, into the gap **1200**G formed by separating the end effectors **1200**E**1**, **1200**E**2** (or **1202**, **1204**) as illustrated in FIG. **39**E. The plicated portion of the stomach is folded to an extent that it is located on the opposite side of the intended plication line, relative to its pre-plicated location, as can be observed by comparing FIG. **39**D with FIG. **39**E. Optionally, but only in variants in which both sides of the stomach are grasped in this procedural embodiment, prior to plicating the portion of the stomach, the operator of the instrument **1200** (or graspers **1202**, **1204**) may rotate the instrument **1200** (or graspers, **1202**, **1204** in concert) to rotate the stomach **3** by about ninety degrees (counterclockwise in the embodiment shown in optional step of FIG. **39**E'). This option positions the stomach to allow gravity to assist in plicating the portion **3**G through the gap **1200**G, making the plicating much easier as the portion **3**G "falls" in through gap **1200**G.

Once the portion **3**G has been plicated appropriately according to either optional technique described above, the instrument **1200**/graspers **1202**, **1204** is/are then operated to rotate the grasping jaws **1206**/end effectors **1200**E**1**, **1200**E**2**/graspers **1202**, **1204** and move them together, into contact with one another, as illustrated in FIG. **39**F. During this step, and throughout the following steps, the instrument(s) and stomach **3** can be maintained in the rotated orientation (as shown in FIG. **39**E') or can be rotated back to the original orientation shown in FIG. **39**F. The end effectors **1200**E**1**, **1200**E**2** or working ends **1202**, **1204** of the graspers when joined as in FIG. **39**F can optionally be provided with joining features **1208**, **1208'**, respectively, to facilitate joining and or strengthen the joint once it has been made. Such joining features may include one or more of, but are not limited to: mating magnets, mating snap elements; mating hook and loop type fasteners, etc.

Next, the surgeon can use a standard laparoscopic needle driver and needle with suture attached thereto, to suture the plication manually. Alternatively, instrument **1250** is mounted over the folded tissue layers of the plication so that third end effector **1250**E**1** and fourth end effector **1250**E**2** are positioned on opposite sides of the tissues as shown in FIG. **39**G. Instrument **1250** can be configured to fit in gaps in the instrument **1200** (or between, distal to, or proximal of grasping jaws of graspers **1202**, **1204**) between sets of grasping jaws **1206**. Although not shown in FIGS. **39**G-**39**K, a layer of material **230** may optionally be mounted in instrument **1250**, like shown and described with regard to FIG. **5**G, which wraps around from the operational surface of end effector **1250**E**1** to the operational surface of end effector **1250**E**2** and overlies the locations of the operational surfaces where the piercing members/suture drivers are driven out from, as well as the locations where the suture anchors are removably mounted. After mounting as described, instrument **1250** is operated to attach the folded tissue surfaces of the stomach together in serosa-to-serosa contact to hold the plication. At the same time the layer of material **230**, when used, is attached to the plication. Material **230** forms a barrier layer that spans the suture line to prevent herniation of the plicated stomach in between the attachment members/sutures, thereby greatly reducing the risk of ischemia. The barrier material may be a sheet or strip of silicone, with or without mesh reinforcement, for example. Whether or not reinforced, the exterior of the strip is silicone, to prevent tissue ingrowth. By preventing tissue ingrowth, this will facilitate reversal of the procedure/plication as the silicone strip will be easily removable.

At FIG. **39**H piercing members/suture drivers **102** (preferably needles, but could alternately be screw drives or other elongated members configured to temporarily attach attachment members/sutures to and to drive through the stomach tissues) are deployed from end effector **1250**E**1** to drive attachment members/sutures **104** through stomach tissues (and material **230**, when used). Suture anchors **106** are removably held in end effector **1250**E**2** and are aligned with the piercing members/suture drivers **102**. Attachment members/sutures **104** are releasably engaged with piercing members/suture drivers **102**. Upon withdrawal of the piercing members/suture drivers, the proximal ends of the suture mates **108**P are retained by the anchors **106** and the suture mates **108** slide off the piercing members/suture drivers **102**, thereby leaving the suture mates **108** and attachment members/sutures **104** installed through the tissues (and, optionally, material **230**) as illustrated in FIG. **39**I. It is noted here that if the optional rotation is performed in FIG. **39**E', then the instrument(s) is/are counter-rotated to return the stomach **3** to the orientation shown in FIG. **39**F, **39**G, **39**H, or **39**I, after performing the procedures described above with regard to FIG. **39**E' or after performing the procedures described above with regard to FIG. **39**F, or after performing the procedures

described above with regard to FIG. **39**G, or after performing the procedures described above with regard to FIG. **39**H.

Attachment members/sutures **104** are also pre-installed through suture locks **110** that are removably mounted on end effector **1250**E**1** and are mounted on attachment members/sutures **104** proximal to the piercing members/suture drivers **102**. Once the attachment members/sutures have been driven and anchored as illustrated in FIG. **39**HI and the stomach **3** has been rotated back to its original orientation, if applicable, instruments **1250** and **1200**/**1202**,**1204** are removed from the patient, leaving the attachment members/sutures **104**, suture locks **110**, (optionally, material **230**) suture anchors **106** and suture anchor mates **108** in place as illustrated in FIG. **39**I. Suture locks **110** have a one-way locking mechanism, such as a ratcheting type mechanism or other arrangement such as directionally oriented teeth that allow suture **104** to be pulled proximally therethrough, but which prevent attachment members/sutures **104** from backsliding distally therethrough. At FIG. **39**J, the attachment members/sutures **104** are cinched by pulling them proximally relative to the suture locks **110** until a desired amount of tension is developed in the attachment members/sutures **104**, as described previously. Cinching can be performed by the use of laparoscopic graspers, for example. The bougie **50**,**50'**,**50"**,**50'"** can then be removed from the patient and the patient can be closed, according to known techniques, to complete the procedure.

As a further option, an expandable implant **10** may be implanted to fill the inside of the plication **3**PL as illustrated in FIG. **39**K. The implant **10** may be a silicone bladder, for example, capable of being inflated by biocompatible fluid such as liquid, gas, or a combination of fluids (gases, liquids, or liquids and gases). Implant **10** is connected via fill tubing **12** in fluid communication with a subcutaneous fill port **80**, so that the fill volume of implant **10** can be adjusted after implanting it as described from a location outside of the abdominal cavity (e.g., by an operator accessing the subcutaneous fill port **80** with a needle alone or a needle attached to a pressurized source of fluid). Other implants **10** may be substituted, but need to be expandable and are preferably controllable as to amount of expansion. A tab or wing **11**, **11'**, **11"**, **11'"** may be provided to extend from the expandable body of the implant **10** and can be inserted between the tissue folds at the plication suture line so that the attachment members/sutures **104** are also installed through the tab or wing **11**, **11'**, **11"**, **11'"** to thereby securely hold the implant in place, as illustrated in FIG. **39**K. The tab or wing **11**, **11'**, **11"**, **11'"** may be made of a mesh-reinforced silicone, for example. Alternatively, the implant **10** may be fixed in place by connecting only to the superior and inferior ends of the plication suture line, or by connecting to one or more of the suture locks **110** and/or suture anchors **106**.

FIG. **44**A illustrates a perspective view embodiment of a handle portion of an instrument capable of operating end effectors designed according to certain aspects of the invention. Handle **1830** is in fluid communication with suction line **116** to provide a connection from suctions ports in the end effectors connected to handle **1830** and a source of negative pressure. Handle **1830** includes actuators **1832** and **1832'**, which are configured to operate the clamping action of the end effectors. Handle **1830** further include locking actuator **1838** which is configured to reversibly lock the end effectors in place and allow the user to release actuators **1832** and **1832'** while maintaining the degree of clamping of the end effectors. Handle **1830** further includes suction actuator **1836**, which is configured to reduce the amount of suction applied to the end effectors. Suction actuator **1836** can be slid or otherwise moved from a first position, corresponding to a full suction, to a second position, corresponding to no suction. Suction actuator **1836** can maintain positions between the first position and the second position to provide intermediate amounts of suction.

FIG. **44**B illustrates a cross-sectional view of handle **1830**. Actuators **1832** and **1832'** are depicted as each being connected via a rod assembly to traveller **1870**, although other mechanical connections between actuators **1832** and **1832'** and traveller **1870** are contemplated as within the scope of these embodiments. According to the embodiment in FIG. **44**B, squeezing one or both of actuators **1832** and **1832'** towards suction line **116** moves traveller **1870** proximally within handle **1830**. Actuators **1832** and **1832'** can be biased in an open position using a spring or a similar mechanism. Alternatively or additionally, traveller **1870** may be biased to in a distal position with handle **1830** using a spring or similar mechanism. Traveller **1870** is connected to pulley **1860** and pulley **1860** moves proximally with traveller **1870** when actuators **1832** and **1832'** cause such proximal movement. Pulley **1860** is engaged with cables (not pictured), which in turn are engaged with end effectors. According to certain embodiments, cables (or a cable) are looped around pulley **1860** such that the cable or cables can move circumferentially with respect to pulley **1860**. An advantage of the cable or cables being looped around pulley **1860**, rather than fixed to pulley **1860**, is that the end-effectors are capable of self-adjusting to the varying thickness of the tissue clamped between them. Locking actuator **1838** is configured to engage traveller **1870** and reversibly lock traveller **1870** in a fixed position. In certain embodiments, locking actuator **1838** includes teeth on a proximal portion and these teeth can engage similar teeth on traveller **1870**. Locking actuator **1838** is configured to pivot about a pivot point to reversibly engage the teeth of the actuator with the teeth of the traveller to provide the reversible locking function. It is understood that other mechanisms for engaging locking actuator **1838** and traveller **1870** are contemplated as within the scope of the invention. Handle **1830** further includes suction actuator **1836**, which is configured to reduce the amount of suction applied to the end effectors. Suction actuator **1836** can be configured to actuate many types of valves capable of being placed the instrument, including butterfly valves, ball valves, toggle valves, and the like.

FIG. **45**A illustrates a cross-sectional view of a clamping mechanism for use with end effectors according to certain embodiments of the invention. FIG. **45**A depicts the proximal portions of end effectors **2100** and **2100'**. In certain aspects of the invention, it may be desirable to maintain a substantially parallel relationship between end effectors during clamping of tissue. The mechanism in FIG. **45**A provides substantially uniform clamping through the use of pairs of slidable arms **2110** and **2110'** connected with pivoting arms **2115** and **2115'**. Arms **2110**, **2110'**, **2115**, and **2115'** may be straight or they may include an angle or curve. Arms **2110**, **2110'**, **2115**, and **2115'** are pivotally connected to end effectors **2100** and **2100'**. Slidable arms **2110** and **2110'** are slidably mounted to sliding rail **2170**. Fixed arms **2115** and **2115'** are also connected to sliding rail **2170** and are configured to provide a clamping force when sliding rail **2170** is advanced distally. Sliding rail **2170** can be advanced distally via a push rod, screw drive, or similar mechanism configured to be actuated by a handle according to embodiments of the invention. Lower arms **2120** and **2120'** include stops that mate with sliding rail **2170** as sliding rail **2170** is moved proximally to reopen end effectors **2100** and **2100'**. Advantageously, the arms and sliding rail of this embodiment are configures to provide a substantially parallel clamping mechanism.

FIG. **45**B illustrates a view of a clamping mechanism and end effectors according to certain embodiments. End effectors **2100** and **2100'** are connected near their proximal and distal end by scissor-type mechanisms. The scissor-type mechanisms include sliding arm **2152**, which is configured to slide within recess **2150**. Sliding arm **2152** is connected to pivoting arm **2154**, which has one and fixed within recess **2150**. Sliding arm **2152** is also connected to push rod **2180**, which has a push rod distal portion **2180**D and a push rod proximal portion **2180**P. When push rod **2180** is pulled proximally, sliding arm **2152** slides within recess **2150** and actuates the clamping of end effectors **2100** and **2100'**. The proximal portions of end effectors **2100** and **2100'** include sliding arm **2152'**, pivoting arm **2154'**, and recess **2150'**, which function to actuate the clamping of end effectors **2100** and **2100'** in a similar manner.

FIG. **45**C illustrates a view of another clamping mechanism according to certain embodiments. End effectors **2100** and **2100'** are illustrated as being connected by a screw-type drive. Threaded nut **2190** is fixed within end effector **2100** such that a threaded rod traveling into cavity **2195** draws end effector **2100'** toward end effector **2100**. The threaded rod or the threaded nut can be actuated from the handle portion of the instrument to facilitate clamping using such a screw-type mechanism.

FIG. **46**A illustrates a view of an end effector assembly according to certain embodiments. End effectors **3100** and **3100'** are connected through telescoping connectors **3150** and **3150'**. In certain embodiments, telescoping connectors include lumens through which negative pressure can be applied to the end effectors and their suction ports. FIG. **46**B illustrates a cross-sectional view of end effectors **3100** and **3100'** and telescoping connector **3150'**. Telescoping connector **3150'** includes a series of nested connecting tubes **3152**, **3154**, **3154'**, **3156**, and **3156'**. These nested connecting tubes have lumens for providing suction, and nest in series to provide telescoping action. The nested connecting tubes have flanged ends which sealingly connect with the adjacent tube. The flanged ends are held within the adjacent tube via a lip on the internal diameter of the adjacent tube. This arrangement of flanges and lips limits the loss of suction flow through the telescoping connector **3150'**. Although FIG. **46**B depicts five nested tubes it is understood that more or fewer tubes may be used to form telescoping connector **3150'**. Telescoping connector **3150'** may be biased in an extended position by placing a spring within the lumens of the nested connectors to hold effectors **3100** and **3100'** apart. Other biasing mechanisms may also be used. Further, telescoping connector **3150'** may be biased closed via negative pressure applied to the instrument and may assume an extended position by being actuated from the handle using mechanisms described herein such as cables, rods, screw drives, and the like. In certain embodiments, a cable runs along the central axis of telescoping connector **3150'** and can be used to limit the extension of telescoping connector **3150'** and/or to provide compression of telescoping connector **3150'** into a compressed position. While not pictured, telescoping connector **3150** is understood to be configured according to any of the ways described for telescoping connector **3150'**. Advantageously, telescoping connectors **3150** and **3150'** nest together with flat sides. The flat sides help maintain a parallel relationship between end effectors **3100** and **3100'** and help prevent torqueing and twisting of one end effector relative to the other during clamping and release of tissue.

FIG. **46**C illustrates a view of a distal portion of an end effector assembly according to certain embodiments. Effectors **3100** and **3100'** are connected via bellows **3180**, which has a corrugated configuration capable of being compressed. Bellows **3180** has a central lumen through which negative pressure may flow to provide suction to end effectors **3100** and **3100'** and their suction ports. Spring **3185** biases bellows **3180** into an extended position. End effectors **3100** and **3100'** can be clamped together using suction or any of the mechanical means described herein. The combination of bellows **3180** and spring **3185** provides desirable fluid communication between end effectors **3100** and **3100'** as well as desirable mechanical separation between and effectors **3100** and **3100'**.

FIGS. **46**D and **46**E illustrate an alternative embodiment of bellows **3180** in which bellows **3180** has a horn-type shape. Bellows **3180** is made from a resilient material such as an elastomer and is configured to preferentially fold or collapse under mechanical force or under the force provided by suction. The resilient characteristic of bellows **3180** enables it to return to its initial shape when such force is removed. FIG. **46**D depicts bellows **3180** in its initial shape and FIG. **46**E depicts bellows **3180** in a collapsed shape.

FIG. **46**F illustrates an alternative embodiment of bellows **3180** in which bellows **3180** connects end effectors **3100** and **3100'** but is not positioned between them. In certain embodiments, bellows **3180** connects and provides fluid communication between end effectors **3100** and **3100'** but is not positioned between them. FIG. **46**F depicts bellows **3180** as a tube having a lumen through which negative pressure may flow. Spring **3185** helps prevent bellows **3180** from collapsing under negative pressure and may also provide a spring force to bias end effectors **3100** and **3100'** apart. End effectors **3100** and **3100'** can be clamped and separated using the mechanical means described herein.

FIG. **47**A illustrates a perspective view of an end effector according to certain embodiments. End effector **3100** includes lumen **3500** through which suction may be applied to suction ports **112**. Suction ports **112** are positioned on end effector **3100** along the edge between the tissue-facing clamping surface and outer surface of the end effector **3100**. Vacuum channels **3510** provide fluid communication between suction ports **112** and lumen **3500**. Vacuum channels **3510** allow negative pressure airflow to be transmitted along a surface within suction ports **112**. Vacuum channels **3150** are sufficiently narrow to prevent the tissue held by the negative pressure from blocking the airflow. This is desirable because blocking airflow may lead to a loss of suction in the system and detachment of the tissue from the clamping surface. FIG. **47**B illustrates cross-section of an end effector according to certain embodiments. Lumen **3500** is in fluid communication with cavity **3550** via constrictor **3560** and optionally via vacuum channels, which are not pictured in FIG. **47**B as it is a cross-section taken down the channel portion of a vacuum channel. Constrictor **3560** limits the volume of air flowing through an uncovered suction port **112**. This serves to preserve vacuum pressure in the lumen. In certain embodiments, a mesh may be placed over the vacuum channels to prevent tissue from pulling into the channels. Such a mesh may be made from plastic or metal or other suitable materials. Advantageously, the mesh may be fabricated separately from the end effector allowing the mesh to be replaced or customized in end effectors.

FIG. **47**C illustrates cross-section of an end effector interacting with stomach tissue according to certain embodiments. Stomach **3** is depicted as having been pulled into the cavity of a suction port of an end effector. Stomach **3** is pulled against mesh **3600**, which excludes stomach **3** from being pulled into channel **3525**. Mesh **3600** meets upper slot lip **3574** at corner **3530**. Preferably, mesh **3600** includes one or more larger openings at corner **3530** to maintain suction against the stom-

ach tissue within the cavity of the suction port. Vacuum at corner **3530** pulls stomach **3** into corner **3530** and combines with the protruding edge on the upper slot lip **3574** to form the stomach into a concave curve against lower slot lip **3572**. This concave curve forms a vacuum seal against lower slot lip **3572** that cannot be broken without first pulling stomach **3** away from the vacuum channel. The increased work required to pull the stomach away from the vacuum channels improves the hold resilience of the slot and provides a physical barrier to the escape of the stomach. Advantageously, the force required to detach the stomach tissue from the suction port of this embodiment is higher than the force required to simply peel stomach tissue from ports formed on the tissue-facing clamping surface of an end effector.

FIG. **47**D illustrates a perspective view of a mesh according to certain embodiments. Mesh **3600** is configured in this embodiment as a molded diffuser having a plurality of circular holes. Without being bound to a particular theory or mechanism of action, it is believed that circular holes are preferred over elongated holes to exclude stomach tissue from being sucked into a cavity. It is believed that stomach tissue is capable of folding and entering elongated slots, but is less capable of stretching to enter circular holes. The holes of mesh **3600** are preferably about 0.010" in diameter, and such hole size can help prevent damage to tissue by excluding it from being folded, crumpled, or otherwise strained within small cavities of an end effector. FIG. **47**D depicts the holes present at corner **3530** when mesh is placed within a suction port of an end effector such as that illustrated in FIG. **47**C. FIG. **47**D depicts a further useful feature of mesh **3600** in that the holes present at corner **3530** are displaced deeper in the vacuum channel than the holes at the major surface of mesh **3600**. The extra depth provided by displacing the holes present at corner **3530** increases the surface area of the concave curve against upper slot lip **3574** when mesh is placed within a suction port of an end effector such as that illustrated in FIG. **47**C. This greater surface area of the concave curve further increases the work required to pull the stomach away from the vacuum channels and further improves the hold resilience of the slot and provides a physical barrier to the escape of the stomach.

FIG. **47**E illustrates an alternative embodiment of a suction slot and channel system for an end effector. FIG. **47**E depicts lumen **3500** as being in fluid connection with cavity **3550** and slot **112**. In this embodiment, the slot and channel system is configured to provide slot lips **3574** and **3574'**, which are each proximate to an opening to lumen **3500** or cavity **3550**, respectively. The openings near slot lips **3574** and **3574'** provide a similar force as described above to form concave curves of stomach tissue within the interior of slot **112**. Such concave curves increase the work required to pull the stomach away from the vacuum channels and improve the hold resilience of the slot and provide a physical barrier to the escape of the stomach.

FIG. **47**F illustrates a cross-section of an alternative suction port for use in an end effector according to certain embodiments. FIG. **47**F depicts suction port **112** with a flexible suction cup **3800** positioned on the tissue-facing side of suction port **112**. Suction cup **3800** include a thin flexible edge, like those used in larger industrial applications to pickup bags of products on automated assembly lines (e.g., bags of potato chips). A very flexible suction cup edge has the advantage that it can move with the tension of the tissue and maintain a seal to avoid allowing leak paths to start which maintains suction better. This thin edge feature is helpful with tissue because while most suction cups attach onto a flat surface (like a window or mirror), stomach tissue can wrinkle, fold, and pull away in a manner that forms leak paths with most rigid suction cups.

FIG. **47**G illustrates a cross-section of an alternative suction port for use in an end effector according to certain embodiments. Suction port **112** includes suction cup **3800**, which in this embodiments is configured to fold into cavity **3550** when suction forces pull tissue into cavity **3550**. Suction cup **3800** is formed from a resilient material, such as an elastomer. By folding inward, suction cup **3800** acts to trap stomach tissue within cavity **3550** and present a physical barrier to the escape of stomach tissue in the event that the suction force becomes diminished. Suction cup **3800** may contain features that reversibly crumple under the force of stomach tissue being sucked into cavity **3550** and such feature similarly form a trap for the captured tissue by providing a physical barrier to tissue escape. Further, it is contemplated that FIG. **47**G depicts an insert to be placed with in the cavity of a suction port. In this embodiment, the insert is flexible and resilient, acts to trap stomach tissue as described above, and is replaceable and customizable.

FIG. **47**H illustrates a perspective view of an alternative suction port for use in an end effector according to certain embodiments. Suction cup **3800** is configured to resemble a grate with elongated slots, which slots allow stomach tissue to fold within them and enter the suction port. In its initial state, suction cup **3800** has a convex configuration with respect to the tissue-facing clamping surface and protrudes outward toward stomach tissue from such tissue-facing surface. Suction cup **3800** is formed from compliant, flexible, and resilient materials such that under the force of tissue being sucked into the suction port, suction cup **3800** inverts into a concave configuration and clamps stomach tissue securely in place. Suction cup **3800** thereby provides an additional physical barrier to the escape of stomach tissue.

FIG. **47**I illustrates a perspective view of an alternative suction port for use in an end effector according to certain embodiments. Suction cup **3800** is configured to include one or more fingers, which protrude into the opening of the suction port. Suction cup **3800** is formed from compliant, flexible, and resilient materials such that under the force of tissue being sucked into the suction port, the fingers of suction cup **3800** fold inward and clamp stomach tissue securely in place. Suction cup **3800** thereby provides an additional physical barrier to the escape of stomach tissue.

FIG. **47**J illustrates a perspective view of an alternative suction port for use in an end effector according to certain embodiments. The suction port includes clips **3850** and **3850'**, which are formed from a resilient material. Under the force of stomach tissue being sucked into the suction port, clips **3850** and **3850'** deflect to engage and capture folds of stomach tissue. Clips **3850** and **3850'** thereby provides an additional physical barrier to the escape of stomach tissue.

FIG. **47**K illustrates a perspective view of an alternative suction port for use in an end effector according to certain embodiments. Suction port **112** includes pleated interior features, which increase the surface area of stomach tissue captured within the suction port and prevent suction from being blocked off by maintaining areas of air flow between certain areas of stomach tissue and the recessed surfaces of suction port **112**.

FIG. **47**L illustrates a perspective view of an alternative suction port for use in an end effector according to certain embodiments. Suction port **112** is configured to have a comparatively small inlet and standoff features to hold tissue away from inlet. The small inlet allows the pressure to build up and create suction when tissue is present, but if tissue pulls

away, the small inlet limits the loss of suction as compared to a larger inlet. The standoffs hold the tissue away to prevent clogging into the small inlet, and instead hold the tissue where a larger diameter of the suction cup engages the tissue.

FIG. **47**M illustrates a perspective view of an alternative suction port for use in an end effector according to certain embodiments. Suction port **112** is configured to have one or more ribs to hold tissue away from the suction inlet. Similar to the standoffs described herein, the ribs hold the tissue away to prevent clogging into the small inlet, and instead hold the tissue where a larger portion of the suction cup engages the tissue.

FIG. **47**N illustrates a perspective view of another alternative suction port for use in an end effector according to certain embodiments. Suction port **112** is configured to have concentric ribs to hold tissue away from the suction inlet. Similar to the standoffs described herein, the ribs hold the tissue away to prevent clogging into the small inlet, and instead hold the tissue where a larger portion of the suction cup engages the tissue.

FIGS. **48**A and **48**B illustrate perspective views of a modular system of end effectors and suction ports. End effector **4100** includes elongate manifold **4110**, which has cutouts configured to accept modular suction ports **4150**. This modular design enables comparatively fast and easy assembly of an end effector with few parts. Suction ports **4150** plug into and clips onto elongate manifold **4110**. Suction ports **4150** can include tapered nipples to help ensure a good seal between the openings of the elongate manifold **4110** and the ports.

FIGS. **49**A and **49**B illustrate perspective views of the function of a stomach tissue engagement system. FIGS. **48**A and **49**B depict an alternate embodiment from that depicted in FIGS. **37**A-**37**C herein. In this embodiment, actuator **138** is drawn proximally relative to the system, which brings lobes **138**L into contact with stomach tissue that has been drawn into slots **112**. To release this secondary clamping, actuator **138** can be moved distally. This tissue clamping complements the engagement and grasping of the stomach **3** tissue by the suction system, and provides a stronger grip on the stomach **3** tissue so that the instrument does not prematurely release its grip on the stomach **3** tissue.

In certain embodiments, the Bernoulli Effect is used to create vacuum at each individual suction port. In such embodiments, compressed gas is directed to the end effecters via tubing. The end effecters are substantially hollow with several openings or ports where suction is desired. Immediately adjacent to each suction port in the hollow portion of the end effector is a small venturi or narrowing which increases the flow velocity locally. According to the Bernoulli Effect, a vacuum is created at the point where the flow becomes narrow. This narrowest portion is connected to the suction port. The advantage of this approach is that the vacuum ports function independently so if one port is open, the others can still pull vacuum. For the embodiments described herein, a source of negative pressure includes suction created by employing the Bernoulli Effect.

While the present invention has been described with reference to the specific embodiments thereof, it should be understood by those skilled in the art that various changes may be made and equivalents may be substituted without departing from the true spirit and scope of the invention. For example, an instrument as described herein may employ suction on one end effector to engage tissue, while providing grasping jaws on an opposite end effector to engage tissue or vice versa. In addition, many modifications may be made to adapt a particular situation, material, composition of matter, process, process step or steps, to the objective, spirit and scope of the present invention. All such modifications are intended to be within the scope of the claims appended hereto.

That which is claimed is:

1. An instrument for use in modifying a patient's stomach by operating on the stomach extragastrically to decrease the effective volume of the patient's stomach, said instrument comprising:

a first elongate end effector formed at a distal end portion of said instrument, said first elongate end effector having a first operational surface configured to contact an external surface of the patient's stomach;

a first plurality of suction ports extending along a length of said first elongate end effector and configured to deliver suction to the external surface of the stomach to engage said first elongate end effector therewith, at least one suction port comprising a means for providing a physical barrier to the escape of a portion of the stomach from the suction port

a second elongate end effector; and

a connector in fluid communication with the first elongate end effector and the second elongate end effector;

wherein the connector comprises telescoping segments.

2. The instrument of claim **1** wherein the means for providing a physical barrier to the escape of the stomach from the suction port comprises at least one suction hole configured to hold the stomach against an interior surface of a lip of the suction port.

3. The instrument of claim **2** wherein the at least one suction hole is configured within a cavity of the suction port to create a concave curve in a portion of the stomach near the interior surface of a lip of the suction port.

4. The instrument of claim **2** wherein the suction port comprises at least one vacuum channel.

5. The instrument of claim **2** wherein the suction port comprises a tissue excluder configured to exclude the stomach from the at least one vacuum channel.

6. The instrument of claim **1** wherein the means for providing a physical barrier to the escape of the stomach from the suction port comprises a resilient member configured to deflect as suction is delivered to the external surface of the stomach.

7. The instrument of claim **6** wherein the resilient member is configured to extend from the first operational surface toward the external surface of the stomach.

8. The instrument of claim **6** wherein the resilient member comprises at least one slot.

9. The instrument of claim **6** wherein the resilient member is configured to extend parallel to an opening of the suction port.

10. The instrument of claim **6** wherein the resilient member is configured to extend from an interior surface of the suction port.

11. The instrument of claim **1** further comprising:

the second elongate end effector formed at a distal end portion of said instrument, said second elongate end effector having a second operational surface configured to contact an external surface of the patient's stomach;

a second plurality of suction ports extending along a length of said second elongate end effector and configured to deliver suction to the external surface of the stomach to engage said second elongate end effector therewith, at least one suction port comprising a means for providing a physical barrier to the escape of the stomach from the suction port.

12. The instrument of claim **1** wherein the connector is biased to hold the first elongate end effector and the second elongate end effector apart from each other.

13. The instrument of claim 1 wherein the connector is biased to hold the first elongate end effector and the second elongate end effector together.

14. An instrument for use in modifying a patient's stomach by operating on the stomach extragastrically to decrease the effective volume of the patient's stomach, said instrument comprising:

at least two elongate end effectors formed at a distal end portion of said instrument;

a plurality of suction ports extending along a length of each elongate end effector;

a resilient and flexible member proximate at least one suction port' wherein the member is configured to provide a physical barrier to the escape of a portion of the stomach from the suction port; and

a connector in fluid communication with the each of the at least two elongate end effectors;

wherein the connector comprises telescoping segments.

15. The instrument of claim 14 wherein at least a portion of the member is within the suction port.

16. The instrument of claim 14 wherein the member is entirely within the suction port.

17. The instrument of claim 14 wherein the member is outside the suction port.

18. An instrument for use in modifying a patient's stomach by operating on the stomach extragastrically to decrease the effective volume of the patient's stomach, said instrument comprising:

at least two elongate end effectors formed at a distal end portion of said instrument;

a plurality of suction ports extending along a length of each elongate end effector and configured to deliver suction to the external surface of the stomach to engage each end effector therewith, wherein at least one port comprises an interior lip configured to maintain contact with the stomach when a portion of the stomach is within the suction port; and

a connector in fluid communication with each of the at least two elongate end effectors;

wherein the connector comprises telescoping segments.

19. The instrument of claim 18 wherein the suction port comprises channels.

20. The instrument of claim 18 wherein the suction port comprises a tissue excluder.

21. The instrument of claim 18 wherein the suction port comprises a suction hole proximate the interior lip.

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